American Optometric Association
NEWS™

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Volume 51 July 2012 No. 1

Supreme Court upholds most of health reform law, AOA-backed provisions anticipated to advance

In an historic ruling issued the morning of June 28, the U.S. Supreme Court largely dismissed challenges to the constitutionality of major provisions of the Affordable Care Act (ACA). While upholding the requirement that individuals purchase health insurance and affirming nearly all of the rest of the law, the Court did take issue with the overhaul's mechanism for compelling states to expand their Medicaid rolls.

Largely ending the uncertainty about the fate of the new health care reform law, the AOA anticipates federal and state-level agencies will now increase efforts to shape state-based health insurance exchanges and implement further provisions of the sweeping new law, including the AOA-backed Harkin Amendment, Stabenow Amendment, and pediatric vision care essential benefit.

"Battling organized medicine, insurers, and others with an anti-optometry agenda, the AOA fought for and won a valued seat at the Washington, D.C., table as the debate over health reform intensified," said AOA's then-president Dori Carlson, O.D.,

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"In the never-ending fight for fairness for our profession, our practices and our patients, we have one voice...our AOA."

Past AOA President Richard Hopping, O.D., at right, prepares to induct the new officers and trustees of the AOA, including his son, Ronald L. Hopping, O.D., MPH (at left). Other officers and trustees, from left, are Immediate Past President Dori M. Carlson, O.D., President-elect Mitchell T. Munson, O.D.; Vice President David A. Cockrell, O.D.; Secretary-treasurer Steven A. Loomis, O.D.; Trustees Andrea Thau, O.D., Christopher Quinn, O.D., Sam Pierce, O.D., Hilary Hawthorne, O.D., Barb Horn, O.D., and William Reynolds, O.D.

AOA elects officers, trustees

Ronald L. Hopping, O.D., MPH, following the footsteps of his father, has taken the office of president of the AOA. Dr. Hopping, of Houston, Texas, was first elected to the board in 2005 and will serve as president for the 2012-2013 program year. Dr. Hopping's father, Richard Hopping, O.D., served as president of the AOA from 1971-1972. This marks the first time in the association's history that a father and son have both held the top office.

Mitchell T. Munson, O.D., has been elected president-elect. Dr. Munson, of Highlands Ranch, Colo., was first appointed to the AOA Board of Trustees in 2006. He previously served as vice president and liaison trustee to the Third Party Center Executive Committee.

David A. Cockrell, O.D., has been elected vice president of the AOA. Dr. Cockrell, of Stillwater, Okla., most recently served on the Legislative Action Response Committee

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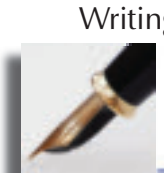
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Survey of DC insiders places AOA on lobbying's top 10 list

The AOA is one of the most effective and respected lobbying operations in Washington, D.C., according to a new survey of congressional offices, policy experts and association executives by *CEO Update*, a national publication that covers the association sector.

Specifically cited in the survey's results is the AOA's multi-year commitment to ensuring that optometry is heard loud and clear in the nation's capital through expanded grassroots advocacy efforts, including the AOA Federal Keyperson Program (*www.aoa.org/ x4826.xml*), AOA-PAC (*www.aoa.org/ x4827.xml*), and the annual AOA Advocacy Conference in Washington, D.C., which swelled to more than 700 OD and student participants this year.

Specifically cited in the survey's results is the AOA's multi-year commitment to ensuring that optometry is heard loud and clear in the nation's capital through expanded grassroots advocacy efforts.

The AOA is also recognized for successes in the two-year Capitol Hill battle over health care reform as well as its leadership role over the last year in uniting a broad coalition of provider groups and free-market think tanks in opposition to a bill backed by organized medicine aimed at imposing strict federal controls on how ODs practice and communicate with their patients.

CEO Update notes that top association lobbyists in Washington, D.C., must "formulate clear policy arguments backed by the group's members, forcefully articulate fundamental points, provide key information to lawmakers, inspire trust in those they seek to influence and never stop fostering the network and contacts arrayed round the playing fields of power."

The survey placed AOA on a 2012 honor roll that includes far larger membership organizations also active on regulatory and legislative policy issues in the nation's capital, including the American Petroleum Institute, the National Association of Manufacturers, the Securities Industry and Financial Markets Association and the U.S. Chamber of Commerce.

According to *CEO Update*, the AOA is the only health care organization included in this year's lobbying top 10 list.

For more information on AOA advocacy and how you can get involved, including through the AOA Federal Keyperson Program and AOA-PAC, contact the AOA Washington office by calling 800-365-2219 or by email at *ImpactWashington DC@aoa.org*.

CMS reaffirms optometry's eligibility for additional PQRS incentive payment

Uncle Sam's current "additional" bonus payment may be relatively small – 0.5 percent – but its significance is huge to special interests in Washington, D.C., working to exclude optometry and gain control over how ODs practice. In fact, if anti-optometry groups had been allowed to have their way, ODs would not be eligible for any of the Medicare physician payment incentives that the AOA's advocacy efforts in Washington have made a reality in recent years.

That's why the June 14 announcement by U.S. Centers for Medicare & Medicaid Services (CMS) officials that optometrists may continue to qualify for the 2012 Physician Quality Reporting System (PQRS) Maintenance of Certification (MOC) Program Incentive represents another notable federal regulatory win for the profession and a key step toward parity at a time when the health care system continues to undergo rapid change.

According to the CMS, the American Board of Optometry (ABO) successfully completed the vetting process to ensure that the ABO MOC program meets its participation requirements again in 2012. The ABO was one of only seven entities that qualified during the launch of this program in 2011, allowing ABO Diplomates to be among an elite few health care professionals to participate in this incentive program.

For 2012, Medicare physicians – including ODs – will again have the opportunity to earn the PQRS incentive, as well as an additional incentive of 0.5 percent by participating in additional activities of a qualified MOC program, including a practice assessment module and patient experience of care survey.

For the latest from CMS on the PQRS MOC Program Incentive, visit *www.cms.gov/Medicare/ Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Maintenance_of_Certification_Program_Incentive.html*.

For the latest health care reform news and information, including background and updates on the PQRS program, visit the AOA's health care reform Web page at *www.aoa.org/reform*.

Now in theaters...

Optometry's Meeting® attendees don 3-D glasses while viewing sneak peeks from upcoming Hollywood flicks.

Hollywood insiders opened the eyes of doctors of optometry, students and paraoptometrics and their famlies to the magic of 3-D possibilities at the Opening General Session for Optometry's Meeting® last month.

Sponsored by Essilor, the session captivated audiences with 3-D clips, many never seen outside the studios, together withexplanations from experts such as Jim Chabin, president of the International 3D Society; Buzz Hayes, senior vice president and executive stereoscopic 3D producer for Sony 3D Technology Center at Sony Pictures Entertainment; Graham Clark of StereoD, LLC; and Bob Whitehill, stereoscopic supervisor at Pixar Animation Studios.

The audience was treated to clips from films such as "The Lion King," "Rise of the Guardians," "Titanic" and "Spiderman."

Following this amazingly entertaining opening session, the media in Chicago picked up on optometry's leadership in understanding and helping optimize the way people see 3-D. Visit *http://bit.ly/Nh1OKJ* to see video of James Sheedy, O.D., Ph.D., explaining how 3-D viewing problems may help diagnose eye problems.

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Writing our own future

Editor's note: this column contains excerpts from the inaugural address given June 30 at the AOA House of Delegates.

Colleagues, and friends, I am deeply honored to serve as president of your American Optometric Association. I give you my pledge and the pledge of this Board that we will work diligently to guide this profession through the many challenges that are squarely before us.

I feel very privileged to be able to work with this talented group of volunteer AOA officers and trustees who spend countless hours, countless days at their homes, at their offices, and on the road away from their families trying their honest best to steer and to lead this profession into the future. We are fortunate to have them. I admire, appreciate, and I thank each of you.

As you know I have had the good fortune to grow up in an optometric family. I was born while my father was studying the first edition of Borish – a pretty thin book back then. My father, with my mother's help, had a large respected practice in Dayton, Ohio, and as a boy I can remember playing in his office. My sister, brother and I would each get on his stool and we could push off the wall at the end of his 20-foot exam room and roll almost all the way across the floor. We had great fun – at least until he caught us.

Optometry has changed a lot since then. In the early fifties, my father opened his practice cold, in a tough location for those days – under the stairs in an old red brick medical building across from a hospital. Today an optometry practice in a medical setting is not unusual. But, it was an important statement back then – a long step from the jewelry stores.

I remember his frames; seems like it was about a total of 20 frames. Folks wore their glasses forever back then since the style never changed. Can you imagine surviving in practice today with virtually no changes in eyewear? And remember contact lenses weren't around yet – and a low vision device was pretty much just a hand magnifier. My hat is off to those who nurtured optometry through those tough times.

I remember seeing an awkward, new instrument in his practice – seems like it was a Pozar biomicroscope. It was the first or second slit lamp in a private practice in that part of Ohio. Today, buying an expensive instrument to examine the front of the eye is expected – but back then it was one of the radical ideas that moved our professional equality forward.

I remember seeing the very first soft contact lenses in their wire rack. They all had to be boiled every night. I remember asking about those and my father telling about his trips to Washington, D.C., and the tough battles they had so optometry could prescribe those lenses because they were regulated by the Food and Drug Administration – and back then everyone knew optometry couldn't use drugs. Fortunately AOA volunteers and staff fought and won that battle and optometry is now a leader in soft contact lenses.

And do some of you also remember as I do when we said good-bye to patients on their 65th birthday because they went on Medicare and optometry wasn't a provider for Medicare? Fortunately we got past the disagreements in our very own profession and again AOA volunteers and staff were able to have us become Medicare providers. Very forward thinking brought us here today.

It is very humbling to me that we are here in 2012 – drinking from the wells we did not dig.

It is very humbling to me that we are here in 2012 – drinking from the wells we did not dig... Today, each of us in this great profession, and every one of our patients, truly benefits from the efforts of many, past and recent leaders, who have dedicated themselves and worked together to bring optometry to where we are today. Through their dedication, their work, their sacrifice and foresight, today optometry is a valuable and essential contributor to our nation's health. Many have given more to us than they have received. I thank each of you.

As we look ahead, we must know that the world my father practiced in is different than the world I practice in today – and yet today is quite different than the world my son and many of us will practice in.

Dr. Hopping

I am well aware, we must all be acutely aware, that our future has not been written. "What future will we write?" Or is the question: "What will others write for us?"

....We must not let anyone else, or anything else, write our future. We are the first-class citizens of vision and eye health care – and I believe, that as our world changes, together, and only together, will we, will the AOA, write the future we want for our patients and for ourselves.

Thank you in this House for your service as leaders of our profession, and I thank you, the members across this nation, for letting me serve as your president. I ask each of you for your help as we work together to write our profession's best future.

Ronald Hopping, O.D., MPH
AOA president

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Big question at Optometry's Meeting®: Who accredits CE providers?

The question of who accredits providers of optometric continuing education was at the forefront of Optometry's Meeting®, with the AOA and the Association of Regulatory Boards of Optometry (ARBO) meeting together June 26, and taking up the issue separately in their business meetings.

The AOA House of Delegates instructed the AOA to work with other organizations – especially ARBO – to create a model for independent accreditation upon which all parties can agree.

According to AOA Trustee Chris Quinn, O.D., the model could be built in one of three ways:

- an organization started from scratch
- through the Council on Optometric Practitioner Education (COPE), if that organization were to be independent of ARBO with broad representative governance
- through the Accreditation Council for Optometric Education (ACOE), which currently accredits professional degree and residency programs.

"The ACOE certainly has an existing infrastructure to conduct accreditation, and it is independent in making accreditation decisions," Dr. Quinn said. "But some in the profession have concerns about the ACOE's ties to the AOA. Therefore, we are calling on all interested parties to provide input on the issue and help the AOA determine a course forward."

Dr. Quinn said there are also concerns that COPE is "controlled by ARBO, is not a recognized accrediting body and is not representative of the profession at large – it only reflects the interests of ARBO."

Dr. Quinn noted that optometry's lack of an independent organization to accredit continuing education sets it apart from other health care fields.

Medicine, for example, relies on the independent Accrediting Council on Continuing Medical Education (ACCME) to evaluate and accredit continuing education providers.

Podiatry has an independent accrediting organization, the Council on Podiatric Medical Education (CPME), similar to ACOE, which "has final authority for the accreditation of colleges of podiatric medicine, the approval of fellowships and residency programs, and sponsors of continuing education."

The AOA House of Delegates instructed the AOA to work with other organizations – especially ARBO – to create a model for independent accreditation upon which all parties can agree.

Although that organization is independent now, it was originally part of the American Medical Association, Dr. Quinn said.

Dr. Quinn expects any profession-wide discussion to continue to study existing models of accreditation and work toward the development of a model that is in the best interest of the profession.

He said the AOA is anxious to hold discussions of the topic with a broad representation of the profession.

"Everyone agrees that an independent accrediting body for optometry CE is a good thing," he said. "A profession takes pride in its ability and willingness to regulate itself, and continuing professional education is no exception to that obligation."

AOAExcel targets needs of 'next-generation optometry'

AOAExcel, a new wholly owned subsidiary of the AOA, was formally established this month to develop an array of "next-generation" products and services that will increasingly be necessary for optometric practice in an era of sweeping health care reforms and rapidly evolving eye and vision care technology, according to a briefing on the project by AOAExcel Chair and AOA Past President Joe E. Ellis, O.D., at Optometry's Meeting®.

AOAExcel products and services will be offered through a new website (*www.ExcelOD.com*), a "one-stop, online shop" that will also provide enhanced access to existing career planning, business management, practice marketing services, and programs such as the AOA Career Center, financial services support, insurance programs, health information technology (HIT)-related services, and coding/billing resources, Dr. Ellis said.

"This is both an exciting and challenging time for our profession. Today our members have to keep up with an ongoing parade of clinical advances and unprecedented change in health care delivery, while simultaneously assuring quality care for patients and the bottom line of practice success," Dr. Ellis told the AOA House of Delegates.

"AOAExcel will meet the needs of next generation optometrists by providing, in a timely manner, all of the products and services they need to remain primary care providers in a health care system that is rapidly moving toward new care models, quality of care measurement, and value-based reimbursement," Dr. Ellis told *AOA News*.

"Our AOA culture of innovation is all about how to better serve members."

"AOAExcel will offer new products and services that may not be readily available in the market but which AOA may be uniquely suited to provide as a nationwide resource for the profession of optometry," Dr. Ellis said.

The new AOA business unit is not intended to compete with product and service providers already in the market, he emphasized.

For example, AOAExcel will not market electronic health record (EHR) systems, which are readily available to optometrists, Dr. Ellis emphasized. However, AOAExcel may offer products that facilitate the use of EHRs, such as interconnectivity networks, that may still not be available to optometrists in many parts of the country, he said.

AOAExcel products and services are being developed primarily as benefits provided free of charge to AOA members. However, as with already-available AOA products and services, some may be offered to members as optional premium services for an additional fee, Dr. Ellis said. Selected products and services may be made available to both AOA member and non-member optometrists but with member optometrists enjoying substantial discounts on any fees.

Products and services offered through AOAExcel will be determined by demand among practicing optometrists. Dr. Ellis is urging optometric leaders at the national and state level to help shape the AOAExcel program by soliciting suggestions from optometrists on the new products or services that they feel will be critical to their practices over the coming years.

The AOAExcel product and service development initiative is being undertaken as part of a comprehensive business innovation plan implemented by AOAExcel Chief Executive Officer and AOA Executive Director Barry Barresi, O.D., Ph.D. Multiple AOA program innovations have been undertaken to improve the membership value while ensuring long-term financial stability of the AOA.

"Our AOA culture of innovation is all about how to better serve members," Dr. Barresi said.

AOAExcel will allow the AOA and its affiliates to continue focusing on advocacy, their primary mission, while increasing the value of association membership by better assisting optometrists with clinical and business issues, Dr. Ellis said.

"The next generation of optometry is about innovation, adaption, and the speed of change. AOAExcel is committed to provide the resources to move all of us to the next level of success, and to enable member OD practices to grow, succeed, and now, Excel," Dr. Ellis said.

Ellis calls on vision plans to halt anti-optometry lobbying, urges ODs not to be bullied

Joe Ellis, O.D., past president of the AOA and Kentucky Optometric Association (KOA), recently called on vision plan executives to immediately halt their anti-optometry lobbying efforts now under way in Washington, D.C., and state capitals around the country, and to work with optometric leaders to lock in the profession's recent legislative and regulatory victories, including the new designation of pediatric vision care as essential and the Harkin patient access law targeting discriminatory Employee Retirement Income Security Act (ERISA) plans.

In a video message to members (*http://youtu.be/u_xdarq35z4*), Dr. Ellis urged optometrists to build on the success of April's AOA Advocacy "Super" Meeting, which brought more than 700 optometrists and optometry students to the nation's capital seeking to build new support for the AOA's patient access agenda, and join with the AOA and state associations in speaking with one voice on Capitol Hill, in statehouses and in forums with discriminatory health plans.

"Right now, when it's more important than ever that our elected officials continue to hear from us, lobbyists for vision plans are urging our senators, congressmen and state legislators to turn back the clock on four decades of optometry's progress, to separate us from the mainstream of health care, to create new barriers to OD-provided medical eye care, and to remake our practices with their very limited vision services as the centerpiece," said Dr. Ellis. "Their lobbying efforts are outrageous, misleading and harmful, and I call on them to stop immediately."

"ODs must not ever be bullied or fooled into allowing others to speak for us or to impose on us their outdated definition of optometry."

Dr. Ellis added, "ODs must not ever be bullied or fooled into allowing others to speak for us or to impose on us their outdated definition of optometry. Consistent with our gains over the last four decades and everything we stand for, optometry must continue to be defined by optometrists."

Dr. Ellis – who led both the KOA and AOA to a series of historic scope and patient access victories – and the AOA Advocacy Group sought to specifically correct two inaccurate claims being made by vision plan lobbyists:

FACT: Vision plans can participate in state health exchanges. The new health care law clearly allows vision plans to participate in all of the state health insurances exchanges by partnering with health plans. Under the approach the AOA has backed, every single one of the millions of children who will gain health insurance mandating full eye health coverage in 2014 will have optometric care integrated into their health coverage.

FACT: Patient Access to optometry will expand. The new health care law is aimed at extending coverage to tens of millions of currently uninsured Americans. Thanks to the pro-active advocacy efforts of the AOA and state associations, there is no provision anywhere in the law that seeks to limit or eliminate anyone's vision coverage. In fact, it expands coverage and patient access to optometric care by designating optometric care as essential, recognizes how optometry has advanced and tells health plans – even ERISA plans – they can't discriminate against ODs any longer.

Dr. Ellis added, "Vision plans must think they – not us – are optometry. They are wrong, and I will continue to speak out and let them know it. Please join me in defending our profession."

The AOA urges optometrists to join Optometry's Full-Scope Defense Team by calling the Washington office at 855-WIN-4ODs or by emailing *defendoptometry@aoa.org*.

HHS launching pilot HIPAA audit program

The Office for Civil Rights (OCR) in the U.S. Department of Health & Human Services (HHS) has announced details of a new audit program designed to check health care entities for compliance with federal rules on the privacy of patient information, the security of health information technology systems, and the notification of patients and regulators when the privacy of patient information is breached.

The OCR's Health Insurance Portability and Accountability (HIPAA) Privacy, Security and Breach Notification Audit Program was officially launched in November 2011 when the agency began developing protocols for a pilot auditing program. Officials announced the protocols in a June 26 post on their HIPAA Privacy and Security Audit Program webpage (*http://tinyurl.com/735uqov*). The pilot program will involve audits of 115 health care entities. It is scheduled to run through December 2012.

The OCR plans to launch a full-scale HIPAA auditing program in 2013.

The program was authorized under the HITECH provisions of the American Recovery and Reinvestment Act of 2009, which requires the HHS to conduct periodic audits to monitor and ensure compliance with HIPAA.

The pilot auditing program will cover:

- HIPPA Privacy Rule requirements for:
- Patient notice of privacy practices for protected health information (PHI),
- Patient rights to request privacy protection for PHI,
- Access of individuals to PHI,
- Administrative requirements,
- Uses and disclosures of PHI,
- Amendment of PHI, and
- Accounting of disclosures of PHI,
- HIPAA Security Rule requirements for:
- Administrative safeguards,
- Physical safeguards, and
- Technical safeguards, as well as
- HIPAA Breach Notification Rule.

The 115 audits in this year's pilot program will cover only health care entities – such as health plans, health care practices, and insurance claim clearinghouses – that are specifically covered under HIPAA. However, business associates that may use or disclose PHI on behalf of HIPAA-covered entities will be included in future audits.

The pilot audit program will cover "as wide a range of types and sizes of covered entities as possible," according to the OCR audit webpage. The HIPAA requirements addressed in the audits may vary based on the type of entity selected for review, according to the OCR.

The OCR audit protocol lists a total of 77 specific HIPAA privacy, security, and breach notification provisions. Auditors will be required to address 40 of those provisions with the option to address 26 others. (Eleven provisions are listed as "not applicable" on the Web site.)

The audits are intended to generate general information about HIPAA compliance, according to the OCR. The pilot program audits will assess not only compliance risks and vulnerabilities, but also best practices that OCR plans to share with the public.

The OCR will not publish lists of audited entities or audit findings that clearly identify the audited entities. However, if an audited entity's audit report indicates a serious compliance issue, the OCR may initiate a compliance review of the audited entity to address the problem. KPMG LLP developed the audit protocols and will act as the auditor.

During the pilot phase, auditors will conduct a site visit for each audited entity and provide the OCR with a report for each. The audited entity will have the opportunity to comment on a draft report. The final report will include the audit's methodology and findings, recommendations regarding the need for corrective action, corrective actions being performed by the audited entity, and best practices identified.

Additional information can be found on the OCR HIPAA Privacy & Security Audit Program webpage or at *www.aoa.org/HIPAA*.

AOA's concerns heard

Hydrocodone reclassification provision withdrawn from final FDA bill

Last month, the U.S. Senate gave final approval to an amended version of the high-priority Food and Drug Administration Safety and Innovation Act (S. 3187) after the AOA and congressional negotiators rejected a provision that would have rolled back optometrists' prescriptive authority in 28 states.

Although the aim of the hydrocodone reclassification provision's sponsors was to target the very real and serious problem of abuse and illegal diversion of hydrocodone-containing substances, the AOA made clear that the approach in the original Senate-passed measure was flawed and would have had serious unintended consequences for ODs and their patients.

Overall, the language would have removed the existing Schedule III classification for certain hydrocodone-containing combinations and would have placed all hydrocodone-containing substances into Schedule II.

For ODs without Schedule II hydrocodone authority, this move would have summarily stripped prescriptive authority for this treatment.

As House-Senate negotiations intensified, the AOA assembled and led a sizeable provider coalition of advanced practice nursing, dental, and other like-minded physician groups, and worked closely with other stakeholders in taking a firm stand against unfair new restrictions on existing prescriptive authority.

In meeting with key lawmakers and providing several detailed briefings on both sides of Capitol Hill, the AOA coordinated closely with the leadership and staff of the West Virginia Association of Optometric Physicians and made full use of the prescribing information provided by the New Jersey Society of Optometric Physicians, the Ohio Optometric Association, and the Georgia Optometric Association, and doctors from across the country.

Instead of rescheduling these substances, the final innovation bill contains a requirement for the Food and Drug Administration (FDA) to hold a public hearing on hydrocodone abuse issues within 60 days, even though the agency already had a similar session scheduled for October.

With the legislative threat successfully addressed for now, the AOA will continue discussions with FDA officials as they consider administrative proposals to respond to hydrocodone abuse and illegal diversion.

AOA members seeking more information on this topic, including those who would like to get more involved as key FDA decisions are made on this topic, should contact the AOA Washington office at 800-365-2219 or *ImpactWashingtonDC@aoa.org*.

For ODs without Schedule II hydrocodone authority, this move would have summarily stripped prescriptive authority for this treatment.

AOA staffer Matt Willette, right, and Sen. Joe Manchin (D-W.Va.) discuss key legislation now before Congress, including an AOA-backed effort to make doctors of optometry eligible, once again, for the National Health Service Corps student loan repayment program (S. 2192).

AOA staffers Jon Hymes, right, and Matt Willette, left, met with Sen. Orrin Hatch (R-Utah) to discuss ongoing health care reform efforts. After winning a hotly contested primary, Sen. Hatch is expected to serve as the top Republican on the powerful Senate Finance Committee in the 113th Congress.

Reform,

from page 1

and president-elect Ronald L. Hopping, O.D., in a joint statement to AOA members issued mere minutes after the Supreme Court handed down its ruling.

"As key health reform decisions are made in the nation's capital and in statehouses across the country in the coming weeks and months, the AOA will continue working to advance pro-access, pro-patient solutions aimed at ensuring that doctors of optometry and their patients are treated fairly under health reform and that policymakers and others fully understand the central role that optometrists play in enhanced care delivery and improved health outcomes," the AOA leaders asserted.

"Today's ruling does put some contentious issues to rest, but it also clearly points to other pressing health care policy questions that still need to be decided. To ensure that optometry continues to be heard loud and clear, we must now re-commit ourselves to the strongest possible links to our U.S. senators and House members through the AOA Federal Keyperson Program (*www.aoa.org/x4826.xml*) and AOA-PAC (*www.aoa.org/x4827.xml*). Please get involved today," Drs. Carlson and Hopping urged.

"In the never-ending fight for fairness for our profession, our practices and our patients, we have one voice... our AOA. Now, with new and even more challenging battles ahead, and groups with an anti-optometry agenda even more intent on defeating us, it's essential for all ODs to join together to make our AOA even stronger, our voice even louder and our victories even more sweeping," Drs. Carlson and Hopping added.

In the days ahead, the AOA will provide further updates and analysis. In the meantime, visit AOA's health care reform page at *www.aoa.org/reform* for the latest news and information from the AOA.

AOA members with questions or comments may contact the Washington office team at 800-365-2219 or *ImpactWashingtonDC@aoa.org*.

AOA affiliates honor ODs making great impact

Jimmy D. Bartlett, O.D.
Alabama Optometric Association

Dr. Jimmy Bartlett is a 1974 graduate of the Southern College of Optometry. Dr. Bartlett has served the AOA in many capacities. He was a consultant to both the Statutory Definition Committee in 1988 and the New Technologies Committee in 1993. In addition, he served on the Prescription Drug Marketing Project Team from 2000 to 2002. Dr. Bartlett is currently a member of the Alabama Prescription Drug Monitoring Committee, representing the Alabama Optometric Association.

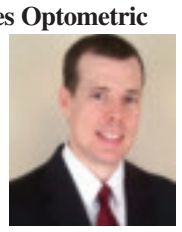
John M. Rinehart, O.D.
Arizona Optometric Association

Dr. John Rinehart is a 1974 graduate of Pacific University College of Optometry. Dr. Rinehart is a member of both the AOA and the Arizona Optometric Association. He currently practices in Peoria, Ariz.

Creighton A. Simmons, O.D.
Arkansas Optometric Association
InfantSEE® Provider

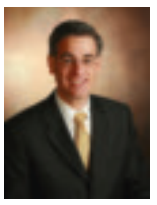
Dr. Creighton Simmons is a 1990 graduate of the Southern College of Optometry. Dr. Simmons serves as chair of the Arkansas Optometric Association (ArOA) State Legislative Committee and also served as president of the ArOA from 2000 to 2001. He currently practices in Benton, Ark.

William Scott Slagle, O.D.
Armed Forces Optometric Society



Dr. Scott Slagle is a 1999 graduate of the Southern College of Optometry. In addition to being an AOA and Armed Forces Optometric Society (AFOS) member, Dr. Slagle is also a member of the Virginia Optometric Association. He maintains consultant status for the Accreditation Council on Optometric Education. Dr. Slagle has also been a member of the AFOS Continuing Education Committee since 2006 and has served as chair since 2009.

Jeffery A. Calmere, O.D.
California Optometric Association
InfantSEE® Provider



Dr. Jeffery Calmere is a 1988 graduate of the University of California at Berkeley School of Optometry. Dr. Calmere is a member of both the AOA and the California Optometric Association. He currently practices in Santa Clara, Calif.

Walter Morton, O.D.
Colorado Optometric Association
InfantSEE® Provider

Dr. Walter Morton is a 1988 graduate of The Ohio State University College of Optometry. Dr. Morton has served on the InfantSEE® Committee, the AOA Foundation InfantSEE® Internet P.R. Subcommittee, and the AOA Foundation InfantSEE® CDC Subcommittee. In addition, he has served as Colorado Optometric Association president. Dr. Morton currently practices in Centennial, Colo.

AOA Immediate Past President Dori Carlson, O.D., presents Rear Adm. Michael Mittelman, O.D., with the AOA Distinguished Service Award at Optometry's Meeting® last month.

Jeffrey L. Kraskin, O.D.
Optometric Society of the District of Columbia

Dr. Jeffrey Kraskin is a 1980 graduate of the Pennsylvania College of Optometry. His AOA committee participation includes serving on the Professional Relations Committee from 1990-1998 and again from 1999-2001. In addition, Dr. Kraskin served as president of the Optometric Society of the District of Columbia. Dr. Kraskin currently has a private practice in Washington, D.C.

Horace Deal, O.D.
Georgia Optometric Association
InfantSEE® Provider

Dr. Horace Deal is a 1997 graduate of the Southern College of Optometry. Dr. Deal has served on the Georgia Optometric Association (GOA) Board of Trustees since 2003, including serving as president from 2009 to 2010. In 2011, Dr. Deal received the GOA's Optometrist of the Year award. He currently practices in Statesboro, Ga.

Millicent L. Knight, O.D.
Illinois Optometric Association
InfantSEE® Provider

Dr. Millicent Knight is a 1987 graduate of the Illinois College of Optometry. Dr. Knight received the Illinois Optometric Association (IOA) Young Optometrist of the Year award in 1999 and its Optometrist of the Year award in 2011. Dr. Knight currently practices in Evanston, Ill.

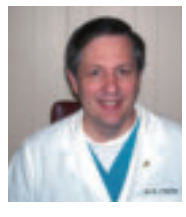
Karen S. Aldridge, O.D.
Kansas Optometric Association

Dr. Karen Aldridge is a 1992 graduate of the University of Missouri-St. Louis College of Optometry. Dr. Aldridge has participated in numerous Kansas Optometric Association (KOA) committees. She also served as president of the KOA Board of Directors from 2001 to 2002. Dr. Aldridge received both the KOA's Young OD of the Year Award and its Distinguished Service Award for Children's Vision Research in 1999. She currently practices in Hill City, Kan.

William T. Reynolds, O.D.
Kentucky Optometric Association
InfantSEE® Provider

Dr. William Reynolds is a 1985 graduate of the Southern College of Optometry. Dr. Reynolds has served on the AOA's State Government Relations Center Executive Committee and was Master of Ceremonies at Optometry's Meeting® in June of 2010 in Orlando, Fla. He has also served as president of the Kentucky Optometric Association in 2001 and Legislative Committee chair from 2005 to 2011.

Mike Haynes, O.D.
Optometry Association of Louisiana
InfantSEE® Provider



Dr. Mike Haynes is a 1981 graduate of the Southern College of Optometry. Dr. Haynes has been a member of the AOA since optometry school and joined the Optometry Association of Louisiana (OAL) immediately after grad-

See ODs of the Year, next page

ODs of the Year,

from previous page

uating from SCO. He served as president of the OAL from 1997 to 1998 and currently serves on the association's Past Presidents' Council. Dr. Haynes currently practices in Monroe, La.

Tracie King, O.D.
Maryland Optometric Association
InfantSEE® Provider

Dr. Tracie King is a 1999 graduate of the Michigan College of Optometry. Dr. King has been extremely active with the Maryland Optometric Association (MOA). She has served on the MOA's Legislative Committee for the last decade and currently chairs the committee. Dr. King is also the MOA's president-elect and will serve as president in 2014. She was named the MOA's Young Optometrist of the Year in 2004. Dr. King has a private practice in Elkridge, Md.

David L. Parker, O.D.
Mississippi Optometric Association
InfantSEE® Provider

Dr. David Parker is a 1995 graduate of the Southern College of Optometry. Dr. Parker currently serves on the AOA's Student and New Graduate Committee. He has served in many capacities for the Mississippi Optometric Association (MOA). Dr. Parker remains active in the MOA and serves on several MOA committees, including the Finance Committee. In 2011, he was named the MOA's OD of the Year. Dr. Parker practices in Olive Branch, Miss.

Stephen Rice, O.D.
Missouri Optometric Association
InfantSEE® Provider

Dr. Stephen Rice is a 1987 graduate of the University of Missouri-St. Louis (UMSL) College of Optometry. Dr. Rice joined the AOA and the Missouri Optometric Association (MOA) while a student at UMSL. He has chaired the MOA's Educational Committee, served on its Governmental Affairs Committee, and was on the MOA Board of Directors from 1994 to 1998. Dr. Rice currently practices in Springfield, Mo.

Jim Devine, O.D.
Nebraska Optometric Association
InfantSEE® Provider

Dr. Jim Devine is a 1983 graduate of the Southern College of Optometry. Dr. Devine sat on the Nebraska Optometric Association's Board of Directors for 10 years and served as president in 1998. Dr. Devine is co-founder and president/chief executive officer of EyeCare Specialties in Lincoln, Neb.

Michael J. Siegel, O.D.
New Jersey Society of Optometric Physicians
InfantSEE® Provider

Dr. Michael Siegel is a 1991 graduate of the State University of New York State College of Optometry. Dr. Siegel has served in every leadership position of the New Jersey Society of Optometric Physicians and its Executive Committee. He served as president in 2010. Dr. Siegel currently practices in Ledgewood, N.J.

AOA Immediate Past President Dori Carlson, O.D., presents Mel Shipp, O.D., Dr.PH, MPH, with the AOA Optometrist of the Year Award at Optometry's Meeting® last month.

David Free, O.D.
Oklahoma Association of Optometric Physicians

Dr. David Free is a 1988 graduate of Northeastern State University. Dr. Free served on the Oklahoma Association of Optometric Physicians (OAOP) Health and Insurance Program Committee for the past two years. He recently became chair of the committee and was also appointed to the association's Health Care Reform Committee. In 2011, Dr. Free was named OAOP's OD of the Year. He currently practices in Tulsa, Okla.

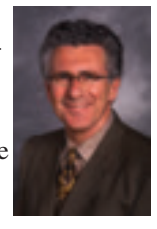
Scott L. Nehring, O.D.
Oregon Optometric Physicians Association
InfantSEE® Provider

Dr. Scott Nehring is a 1983 graduate of the Pacific University College of Optometry. Dr. Nehring has served on the Oregon Optometric Physicians Association (OOPA) Board for many years. He currently serves as president of the Great Western Council of Optometry. He was the OOPA Optometrist of the Year in 1993 and again in 2011. Dr. Nehring currently practices in Woodburn, Ore.

Charles J. Falsone, O.D.
Pennsylvania Optometric Association

Dr. Charles Falsone is a 1998 graduate of the Pennsylvania College of Optometry. Dr. Falsone is a member of the both the AOA and the Pennsylvania Optometric Association (POA). In addition, he serves as the POA's House Member Coordinator for the Legislative Affairs Committee.

Kevin Katz, O.D.
Texas Optometric Association
InfantSEE® Provider



Dr. Kevin Katz is a 1979 graduate of the University of Houston College of Optometry. Dr. Katz is the Texas Optometric Association (TOA) immediate past president and received its Optometrist of the Year award at the association's 112th convention in February.

George F. Brown, O.D.
Virginia Optometric Association

Dr. George Brown is a 1981 graduate of the Pennsylvania College of Optometry. He is past president of the Virginia Optometric Association, serving on the Board of Trustees since 2000. Dr. Brown currently practices in Springfield, Va.

Lori Z. Youngman, O.D.
Optometric Physicians of Washington

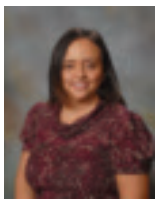
Dr. Lori Youngman is a 1994 graduate of Pacific University College of Optometry. Dr. Youngman served on the AOA's Membership Development Committee from 2009 to 2011. She was also president of the Optometric Physicians of Washington in 2006.

Michelle Harper, O.D.
Wisconsin Optometric Association
InfantSEE® Provider

Dr. Michelle Harper is a 1993 graduate of the University of Houston College of Optometry. Dr. Harper served on the Wisconsin Optometric Association (WOA) Board of Directors for eight years. She has also served as the WOA's Education Committee co-chair. Dr. Harper currently practices in Sturgeon Bay, Wis.

Affiliates give high honors to Young ODs of the Year

Marcela Frazier, O.D.
Alabama Optometric Association
InfantSEE® Provider



Dr. Marcela Frazier is a 2002 graduate of the University of Alabama at Birmingham (UAB) School of Optometry. Dr. Frazier is an assistant professor in Pediatric Services at the UAB School of Optometry and is involved with Volunteer Optometric Services to Humanity.

David Coulson, O.D.
Arizona Optometric Association

Dr. David Coulson is a 2007 graduate of the Pacific University College of Optometry. He is the Arizona Optometric Association Membership Committee co-chair. He also volunteers with Special Olympics.

James Hertzog, O.D.
Arkansas Optometric Association
InfantSEE® Provider

Dr. James Hertzog is a 2006 graduate of the Southern College of Optometry. Dr. Hertzog received the Young OD of the Year Award from the Arkansas Optometric Association in 2011. He currently practices in Cabot, Ark.

Maj. John Kim, O.D.
Armed Forces Optometric Society

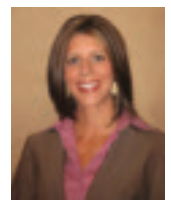
Maj. John Kim is a 2001 graduate of the Southern California College of Optometry. Maj. Kim is a member of the Armed Forces Optometric Society Continuing Education Committee and Executive Council.

Katherine Witmeyer, O.D.
California Optometric Association
InfantSEE® Provider

Dr. Katherine Witmeyer is a 2003 graduate of the University of California at Berkeley School of Optometry. Dr. Witmeyer is a founding member and current secretary of the California Optometric Asssociation Low Vision Rehabilitation Section.

Tara Peterson, O.D.
Colorado Optometric Association
InfantSEE® Provider

Dr. Tara Peterson is a 2005 graduate of the Pacific University College of Optometry. Dr. Peterson was elected to the Colorado Optometric Association (COA) Board of Trustees in 2011. She also received the COA's Young Optometrist of the Year Award in 2011. Dr. Peterson is owner and partner of Mountain Vista EyeCare and Dry Eye Center in Littleton, Colo.



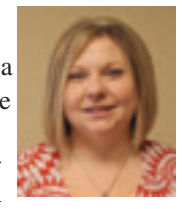
Denise Burns-LeGros, O.D.
Florida Optometric Association

Dr. Denise Burns-LeGros is a 2005 graduate of the Nova Southeastern University College of Optometry. Dr. Burns-LeGros has served as the Florida Optometric Association (FOA) conference chair for the last two years. She was the recipient of the FOA's Young Optometrist of the Year award in 2011.

Andrew Solomon, O.D.
Georgia Optometric Association

Dr. Andrew Solomon is a 2007 graduate of the University of Alabama at Birmingham School of Optometry. In 2011, he was the recipient of the Georgia Optometric Association Young Optometrist of the Year award.

Angela Oberreiter, O.D.
Illinois Optometric Association
InfantSEE® Provider



Dr. Angela Oberreiter is a 2005 graduate of the University of Missouri—St. Louis College of Optometry. In 2011, Dr. Oberreiter was the recipient of the Illinois Optometric Association Young Optometrist of the Year Award. She currently practices in Springfield, Ill.

Bradford Majher, O.D.
Kansas Optometric Association
InfantSEE® Provider

Dr. Bradford Majher is a 2001 graduate of the Southern College of Optometry. Dr. Majher is chair of the Kansas Optometric Association (KOA) Assistance to Graduates and Undergraduates/New OD Committee. He is also a member of the KOA's Political Action Committee. Dr. Majher currently practices in Wichita, Kan.

William R. Davis, O.D., Maryland Optometric Association

Dr. William Davis is a 2003 graduate of The Ohio State University College of Optometry. Dr. Davis has served as the Maryland Optometric Association (MOA) education chair since 2009. He also received the MOA's Young Optometrist of the Year award in 2011.

Matthew Johnson, O.D.
Michigan Optometric Association

Dr. Matthew Johnson is a 2007 graduate of the Michigan College of Optometry. He is an active member of the AOA's Vision Rehabilitation Section. Dr. Johnson is also a member of the MOA's Low Vision, Social Media, and Continuing Education committees. He currently practices in Battle Creek, Mich.

Tonyatta Hairston, O.D.
Mississippi Optometric Association
InfantSEE® Provider

Dr. Tonyatta Hairston is a 2001 graduate of the Southern College of Optometry. Dr. Hairston is the current chair of the Mississippi Optometric Association Public Relations Committee. She is the owner and chief executive officer of EnVision Eye Care and Optical Boutique of Jackson, Miss.

Jeffrey Gamble, O.D.
Missouri Optometric Association

Dr. Jeffrey Gamble is a 2002 graduate of the Northeastern State University Oklahoma College of Optometry. Dr. Gamble serves on the Missouri Optometric Association (MOA) Board of Directors. He also serves on the MOA's Public Relations and PAC committees. He currently practices in Columbia, Mo.

William E. Thomas, O.D.
Montana Optometric Association

Dr. William Thomas is a 2005 graduate of the Indiana University School of Optometry. Dr. Thomas has been on the Montana Optometric Association (MOA) Board since 2007. He has served as a member of the MOA Public Health Committee and as chair since 2010. Dr. Thomas owns a private practice in Missoula, Mont.

AOA Immediate Past President Dori Carlson, O.D., presents Chris Wroten, O.D., with the AOA Young Optometrist of the Year Award at Optometry's Meeting® last month.

See Young ODs, next page

Young ODs,

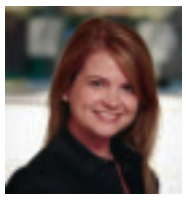
from previous page

AOA Immediate Past President Dori Carlson, O.D., presents Vera Kohler, CPOA, with the AOA Paraoptometric of the Year Award at Optometry's Meeting® last month.

Creston Myers, O.D.
Nebraska Optometric Association

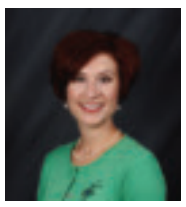
Dr. Creston Myers is a 2003 graduate of the Indiana University School of Optometry. Dr. Myers currently serves on the NOA Board of Directors.

Allison LaFata, O.D.
New Jersey Society of Optometric Physicians



Dr. Allison LaFata is a 2005 graduate of the State University of New York State College of Optometry. Dr. LaFata runs the student extern program at Omni Eye Services. She is a Diplomate of the American Board of Optometry.

Andrea E. Bethel, O.D.
New Mexico Optometric Association
InfantSEE® Provider



Dr. Andrea Bethel is a 2006 graduate of the Southern College of Optometry. Dr. Bethel is the secretary of the New Mexico Optometric Association (NMOA). She was the recipient of the NMOA's 2011 Young Optometrist of the Year award.

Mile Brujic, O.D.
Ohio Optometric Association
InfantSEE® Provider

Dr. Mile Brujic is a 2002 graduate of the New England College of Optometry. Dr. Brujic serves on the AOA's Meetings Center Executive Committee CE Subcommittee. Dr. Brujic has also served as chair of Ohio's Allied Eye Professionals (AEP) Section. In 2011, he received the Ohio Optometric Association Young Optometrist of the Year award. Dr. Brujic currently resides in Bowling Green, Ohio.

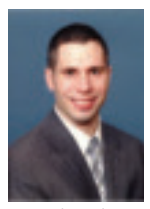
Zeddie Cantrell, Jr., O.D.
Oklahoma Association of Optometric Physicians
InfantSEE® Provider

Dr. Zeddie Cantrell is a 2006 graduate of the Northeastern State University Oklahoma College of Optometry. He is an active member of AOA's Contact Lens & Cornea Section. Dr. Cantrell was also the 2011 recipient of the Oklahoma Association of Optometric Physicians Young OD of the Year Award.

Jonathan Berry, O.D.
Oregon Optometric Physicians Association

Dr. Jonathan Berry is a 2005 graduate of the Pacific University College of Optometry. Dr. Berry has served on the Oregon Optometric Physicians Association Legislative Committee as state Keyperson coordinator. He currently practices in Albany, Ore.

Matthew A. Mastrine, O.D.
Pennsylvania Optometric Association

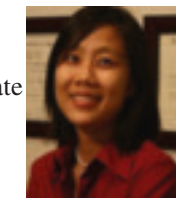


Dr. Matthew Mastrine is a 2008 graduate of the Pennsylvania College of Optometry. Dr. Mastrine is an active member of the AOA's Contact Lens & Cornea Section.

Peter J. Cass, O.D.
Texas Optometric Association
InfantSEE® Provider

Dr. Peter Cass is a 2000 graduate of the University of Houston College of Optometry. Dr. Cass is a member of the AOA's Contact Lens & Cornea Section. He is also chair of the Texas Optometric Association's Health Information Technology Committee.

Jen Weigel, O.D.
Virginia Optometric Association

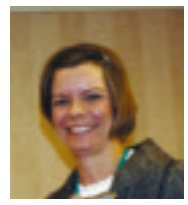


Dr. Jen Weigel is a 2004 graduate of the Southern College of Optometry. Dr. Weigel has served on the Virginia Optometric Association Board of Trustees since 2009 and has been chair of its Membership Committee since 2008.

Melissa Dacumos-Pizarro, O.D.
Optometric Physicians of Washington

Dr. Melissa Dacumos-Pizarro is a 2004 graduate from the University of California at Berkeley School of Optometry. In addition to being an AOA member, Dr. Dacumos-Pizarro is also co-chair of the Optometric Physicians of Washington (OPW) Student Membership Committee. She was named the OPW's Young OD of the Year in 2011.

Callie Enyart, O.D.
Wisconsin Optometric Association
InfantSEE® Provider



Dr. Callie Enyart is a 2001 graduate of the Illinois College of Optometry. Dr. Enyart has been on the Wisconsin Optometric Association Board of Directors for six years. She is also its current Education Committee chair.

Staffing the OptometryStudents.com booth at Optometry's Meeting® were, from left, Matt Geller (State University of New York State College of Optometry [SUNY]), Aliasghar Jagani (Illinois College of Optometry), Rae Huang (SUNY), Rajat Shetty (SUNY), Jie Tian (SUNY), and Lamees Alshawkani (SUNY). Students from the New England College of Optometry and Pennsylvania College of Optometry also helped staff the booth.

Risks continue as board certification case goes to trial

Following action by the AOA's House of Delegates and outreach to other organizations by the AOA, a federal judge has agreed to correct statements in court documents that say optometrists "are not physicians."

The corrected statement now reads: "Optometrists are professionals who perform eye exams and check for vision problems and diseases, but they are not medical doctors (M.D.s)."

In response to presentations by AOA Special Counsel Wayne Henry, J.D., and AOA's Advocacy Group in the AOA House of Delegates on June 29, the House approved two substantive motions reaffirming the AOA's commitment to defend the status of optometrists as physicians in federal law. Both motions passed unanimously, with 2,075 votes cast in favor.

The first substantive motion calls for the AOA Board of Trustees "to reaffirm and defend the physician status of optometrists by any and all available means."

The second substantive motion calls upon the American Optometric Society (AOS) to join the AOA in petitioning a federal judge to correct his June 12, 2012, order stating optometrists "are not physicians."

That statement was included in a summary judgment order issued by U.S. District Judge A. Howard Matz in a lawsuit filed by the AOS against the American Board of Optometry (ABO).

The AOA was alarmed that one of the outcomes of the AOS/ABO lawsuit could be a statement in federal court that potentially undermines years of effort to advance and defend the standing of the optometry profession under federal law.

The AOA is pleased to announce that, in keeping with AOA's outreach efforts, the AOS requested that Judge Matz correct the statement that optometrists "are not physicians." Judge Matz's ruling now states that optometrists "are not medical doctors (M.D.s)."

On stage at the House of Delegates June 29 to discuss the seriousness of the concerns posed by a judge's statement that optometrists "are not physicians," are, from left, past AOA President Joe Ellis, O.D., Assistant Director of Regulatory Policy & Outreach Rodney Peele; Washington Office Director Jon Hymes; Special Counsel Wayne Henry, J.D.; Associate Director of Advocacy and Affiliate Outreach Brian Reuwer and Third Party Center Director Lendy Pridgen.

AOA leadership termed the move by the AOS to correct the statement as, "one step in the right direction of protecting the physician status of optometrists under federal law, which should be of paramount importance to all optometrists."

AOA President Ron Hopping, O.D., MPH, said the two votes, representing the unanimous voice of the House of Delegates, demonstrated widespread concern in the profession about the consequences of the lawsuit and the lawsuit's potential to set back decades of successful advocacy by the AOA to advance the profession.

Wayne Henry is still concerned with AOS tactics in this suit. "Unfortunately, the risk is still present that actions in this trial could compromise optometry's status of equal treatment within the mainstream of health care."

"We are gratified that the court documents have been corrected, but we remain concerned that the topic of optometrists' hard-won status as physicians surfaced at all," Dr. Hopping said. "The AOA's Advocacy Group is working hard to ensure there is no residual damage to our profession from this ill-advised episode."

Immediate Past President Dori M. Carlson, O.D., has noted, "The classification of optometrists as physicians under federal statute is one of the AOA's most significant accomplishments of the past quarter century. It is the AOA's view that physician status underpins all of AOA and AOA affiliates' efforts to maintain equality of access to patients. The AOA will continue to vigorously reaffirm and defend that physician status, and calls upon all optometrists and optometric organizations to do the same."

The U.S. District Court, Central District of California, granted the ABO's motions related to two of the three claims alleged by the AOS. The Court agreed with the ABO's request for a judgment in its favor on both of the AOS's state law claims for false advertising and unfair competition.

The Court, in denying the ABO's motion as to the final claim, simply indicated that the claim will need to be played out at trial.

"The AOS's obsession with bringing down the process and the profession will not deter us from optometry's directive to build a strong board certification program," said Paul C. Ajamian, O.D., who chairs the ABO board and is a Diplomate.

The trial was scheduled for July 31-Aug. 2 in Los Angeles.

A ruling had not been issued at press time. For further updates, check the AOA News blog at *www.newsfromaoa.org*.

Board,

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and is the liaison trustee to the Affiliate Relations and Membership Group, Faculty Relations, Membership Development and Student and New Graduate committees.

Steven A. Loomis, O.D., of Roxborough Park, Colo., has been elected AOA secretary-treasurer. He most recently served as a trustee and is a past chair of the AOA State Government Relations Center, Oversight Board, AOA Health Care Legislative Committee and the Resolutions and the Legal Defense Fund Oversight committees.

Hilary L. Hawthorne, O.D., has been re-elected to the AOA Board of Trustees. Dr. Hawthorne, of Los Angeles, Calif., was officially appointed to the AOA volunteer structure in 2006. She has been active in the AOA Communications Advisory Group and served as chair of the Credentials Committee and the Hispanic Communications Project Team from 2008-2009.

Christopher Quinn, O.D., has been re-elected to the AOA Board of Trustees. Dr. Quinn, of Iselin, N.J., currently serves as the liaison trustee to the Advocacy Group, Community Health Center, Federal Legislative Action Keyperson, Federal Relations, Legislative Action Response, and Professional Relations committees.

William T. Reynolds, O.D., has been elected to the AOA Board. Dr. Reynolds, of Richmond, Ky., has a long history of service to optometry on the state, regional and national levels. His dedication to the profession resulted in him twice being awarded the Kentucky Optometric Association (KOA) OD of the Year, in 1998 and 2011. He was also a three-time winner of the KOA President's Award and was instrumental in passing the Children's School Entrance Eye Exam Law in 2000 and the Better Access to Quality Eye Care bill in 2011.

Dori M. Carlson, O.D., of Park River, N.D., will assume the AOA office of immediate past-president. Dr. Carlson was the first woman to serve as AOA president and was first elected to the board in June 2004. During her tenure on the AOA Board, Dr. Carlson served as liaison to many different committees and project teams. Most notably she was instrumental in developing the School Readiness Summit: Focus on Vision, which evolved into a Joint Statement signed by 30 different organizations calling for a comprehensive eye exam to be the foundation of children's vision care. This statement was used in the AOA's lobbying efforts to define the essential pediatric vision benefit in health care reform as an eye exam instead of a simple screening.

The other trustees continuing to serve are Barb Horn, O.D., Sam Pierce, O.D., and Andrea Thau, O.D.

Dr. Horn has served as chair of the Clinical and Practice Advancement Group Executive Committee, the Information & Member Services Group and the Student Awareness Project Team.

Dr. Pierce has served on the AOA Communications Advisory Group, Nominating Committee, Professional Relations Committee and Student and New Graduate Committee.

Dr. Thau was a founding member of the InfantSEE® Committee. She is a past chair of the Credentials Committee and served on the AOA Pediatrics and Binocular Vision Committee, the first Faculty Relations Committee and the Bylaws Project team.

Kentucky bans vision plan 'fee capping' for non-covered services

Kentucky has become the first state in the nation to prohibit vision care insurance plans from establishing the fees that vision care providers can charge for products or services that the plans do not cover under their benefit packages.

The new restriction on "fee capping" by vision plans comes as part of an amendment to Kentucky's insurance law that bars all limited health insurance programs from establishing reimbursements for non-covered services (NCS).

"A participating provider agreement shall not require a participating provider to provide services to an enrolled participant at a fee set by or subject to the approval of the limited health service benefit plan unless the services are covered services under the provider agreement," the new Kentucky law stipulates.

The provision applies to any insurance company, health maintenance organization, self-insurer or multiple employer welfare arrangement not exempt from state regulation by the federal Employee Retirement and Income Security Act (ERISA), provider-sponsored integrated health delivery network, self-insured employer-organized association, nonprofit hospital, medical-surgical, dental, health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky that offers a limited health service benefit plan.

The new ban on fee capping for non-covered services in Kentucky takes effect this month.

The banning of NCS fee capping has become an important, emerging trend in the regulation of dental plans, the AOA State Government Relations Center (AOA-SGRC) noted.

More than half of all states (27) have enacted legislation barring dental plans from establishing fees for non-covered services – all of them over just the past two years, according to the American Dental Association (ADA) Department of State Government Affairs, which has made a priority of such legislation.

However, the Kentucky law appears to be among the first to broadly bar NCS fee capping by virtually all limited health insurance programs and certainly the first to ban the practice among vision plans, according to the AOA-SGRC.

Vision plan provider contracts commonly limit the maximum fees participating optometrists can charge for products or services – such as a second pair of eyeglasses – that are not covered by the plan, noted William Reynolds, O.D., legislative chair for the Kentucky Optometric Association (KOA) and AOA trustee.

KOA Executive Director Darlene Eakin noted insurance companies often feature both covered benefits and discounts on non-covered services in their marketing materials, suggesting beneficiaries are getting both in return for their premium payments.

However, fee capping arrangements effectively shifted the cost of offering those discounts from insurers to health care providers, she maintains.

"Fee capping for non-covered services involves the insurance plan in a private transaction between the doctor and the patient. Non-covered products and services represent options the patient chooses to pay for out-of-pocket. The new law will not

See Kentucky, page 36

Hopping calls for unity during time of change

The Supreme Court's health care law decision heralds the way for dramatic health care reform in the nation, AOA President Ronald Hopping, O.D., MPH, said in his address to the AOA House of Delegates last month.

"Yet throughout all these revolutionary changes, I firmly believe optometry will continue to be a valuable and essential contributor to our nation's health – and I mean all areas of optometry: vision and eye health care, vision therapy, vision rehab, vision enhancement," Dr. Hopping said. "Optometry provides the overwhelming amount of eye care in this country, and the demographics of our nation's population are clear. As our nation ages, even more optometric services will be needed."

As changes occur, the AOA remains committed to assuring patients' access to care and that ODs are paid fairly and equally for equal care, equal service, and equal responsibility.

"Change is very uncomfortable, and yet our profession must anticipate these changes as best as possible," he said. "I promise you, the AOA will continue to take its role as scout and advocate for our profession very seriously. Most of the time the AOA has been remarkably good at anticipating change – and we have had astounding success over many decades, and frankly, sometimes we have missed the mark. But in all cases we did the best we could with the resources we had. Most importantly, we kept optometry and our patients as our primary concern. No one else watches out for my profession, for our profession. I promise you the AOA will continue to keep optometry and our patients first."

Dr. Hopping called on members to decide if the AOA should be a proactive or reactive association.

"Will we be proactive – do you want us to try to anticipate change as best as possible and prepare for that change, or will we be reactive – will we let the world do what it does and then try to adapt?" he asked. "Our history is full of examples when optometry had hard and difficult discussions on the correct path to take. We were a proactive profession when we went for the use of diagnostic drugs even though many optometrists held firmly to our being a drugless profession and quit and went home. We were proactive when we went for the use of therapeutic drugs, even though many didn't want to make that uncomfortable change."

Optometry has only been successful, and optometry has been very successful, because after our disagreements we all joined together.

Board certification is another area in which the profession is proactive.

"I know this is a very sensitive issue in our profession, and only time will tell how necessary that painful experience was. But as our world around us continues to change, it is even more clear today, in 2012, that without recognized, and voluntary, board certification, optometry will be treated, and paid, as second-class citizens in the new world of health care. We are the first-class citizens of vision and eye health care – and optometry must participate in our nation's health care as first-class citizens…

"Throughout our history we have had many serious disagreements in our profession, and we will have more. In our hundred-plus years, some discussions have, in fact, been more difficult than our recent discussion. But historically, at the end of the day, after the discussions, the passion, the disagreements, and the votes, we all realized we are one family and we all moved on, and forward, together.

"As we move forward we must constantly remember that not only are we one family – we are a small family, a small profession. Compared to the rest of the health care world we are very small in numbers. Yes, we're big in heart and essential to health care, but we are small in numbers. Optometry has only been successful, and optometry has been very successful, because after our disagreements we all joined together. In writing our future, we will only continue to be successful if we all contribute and work together. We are too small to succeed otherwise," he said.

Dr. Hopping encouraged further discussion on AOAConnect. "I know discussion may lead to agreement or disagreement and either is good for our association. But, discussion is only good if it is educated, is honest, and with the best interest of the entire profession in our hearts."

Visit *connect.aoa.org* to join in.

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‘KanLovKids’ state program gives new hope to children with low vision and their families

KanLovKids is an initiative of the Kansas Optometric Association (KOA), Kansas State School for the Blind (KSSB) and Kansas Lions Sight Foundation (KLSF) that provides low vision evaluation and rehabilitation services to children from birth to 22 years.

With much of Kansas being rural, some residents may have to travel for two hours or more for basic health care and even longer for specialized care such as low vision.

The KanLovKids program is able to provide low vision rehabilitation services to children and their families close to home.

The KSSB serves as the KanLovKids program’s anchor organization, and through its outreach department implemented a statewide Low Vision (LV) and Pediatric Low Vision Collaboration Clinic (PLVCC), conducted by 11 doctors at various locations across the state.

These 11 doctors have significant experience working with children with low vision, including those with additional disabilities.

The clinics assist families and service providers in better understanding low vision eye conditions in children.

Diagnostic services, glasses, low vision devices, and individualized accommodations and intervention strategies are provided, and low vision devices are specifically prescribed for near (reading), intermediate (computer), and distance (reading blackboard, street signs) activities of daily living.

“Children with low vision face special challenges in school, at home, and in the community, where great emphasis is placed on learning through sight,” said Anne S. Nielsen, Ph.D., KSSB outreach coordinator. “Designed by a community of practice members, including low vision optometrists, ophthalmologists, the KOA, Kansas Lions and the KSSB, the KanLovKids program addresses these challenges.”

In the fall of 2011, the KanLovKids program received a boost in funding from the Lions Club International Foundation, which was the first-ever grant for low vision services in the United States.

Giving hope

In an effort to support this program, a KanLovKids doctor, Kendall Krug, O.D., developed a secure database using statewide low vision evaluation forms that were completed by the KanLovKids doctors on all children.

This database contributed greatly toward the program’s success, but it could not be accessed through the Web.

To help with this problem, the KOA was awarded a $4,000 Healthy Eyes Healthy People® (HEHP) grant in April 2012 for improvements in database access.

“In Kansas, there are 1,054 children, birth through grade 12, who are legally blind. Of these, only 100 will attend the KSSB in Kansas City,” Dr. Krug said. “Thanks to the KanLovKids program, 90 percent of visually impaired students are able to stay in their home school district and have access to low vision optometrists, aids and techniques to help them lead normal lives.”

See KanLovKids, next page

Jim Lawlor, a certified orientation and mobility specialist, helps a child try out her monocular vision as part of the low vision evaluation.

Linda Lawrence, O.D., uses the Hiding Heidi Low Contrast Face Test to assess a child's facial recognition ability.

Kendall Krug, O.D., tests the near vision of a student who benefitted from extra lighting.

KanLovKids,

from previous page

HEHP grant funding further leverages the success of the database by making it readily available in a Web-based format.

This ensures accurate and widespread collection of data, while increasing and improving reporting capabilities for the entire KanLovKids effort, no matter where children are receiving a low vision evaluation in the state.

The KanLovKids program makes it affordable for children with low vision to be treated. The price for a low vision evaluation is $250.

KanLovKids providers offer a $100 discount, the KLSF contributes $100 toward each evaluation and school districts are billed $50 per child and are expected to cover recommended corrective devices, as required by the Individuals with Disabilities Education Act (IDEA).

"This program is important because low vision evaluations are not covered by medical insurance providers," Dr. Krug noted.

Before, if a child's parents didn't have the financial resources, a child with low vision often would not receive the treatment and technology to see.

Dr. Krug continued, "Vision contributes 83 percent to learning. Getting access to corrective technology is important because 75 percent of children in Kansas who are legally blind or visually impaired will be able to read using telescopes, lighted magnifiers and other adaptive technology."

However, the problem is finding the money.

"This program allows us to reach more kids and give parents hope, despite school budget cuts," Dr. Krug said.

According to Todd Fleischer, KOA director of communications and KanLovKids HEHP grant collaborator, "The KanLovKids' database is a critical component as it allows the program to collect significant information for understanding and helping this underserved population of children. The goal of the database is to allow all team members to have access to the vision information on each child, so that recommendations for devices and training are available for Teachers of students who are Visually Impaired (TVIs), Certified Orientation and Mobility Specialists (COMS) and special educators who work with the children in school or at home."

Growing community

Since the KanLovKids program began in 2007, 548 children have been evaluated, with more added every year.

In the 2011-2012 school year, 153 children were evaluated and 550 parents and team members attended and participated.

Optometrists, special educators, teachers, and specialists working together with low vision children and their families, with support from the KSSB, KOA, KLSF and Lions Clubs International Foundation, make the KanLovKids program and its Web-accessible database a great example for other states in need of a low vision program.

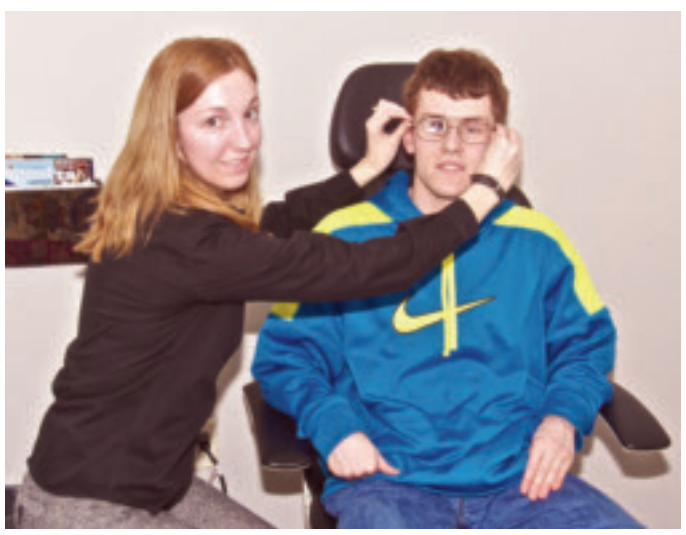
To learn more, contact Todd Fleischer at the Kansas Optometric Association, 785-232-0225.

Special thanks to these KanLovKids low vision ODs for making a difference in children's lives:

Robert Hoch, O.D., Garden City
Shane Kannarr, O.D., Pittsburg
Kendall Krug, O.D., Hays
Linda Lawrence, M.D., Salina
Joseph Maino, O.D., Kansas City
David Nelson, O.D., Topeka
Kristina Post, O.D., Wichita
William Park, O.D., Wichita
Mark Wahlmeier, O.D., Colby
Dawn Williams, O.D., Garden City
Todd Zerger, O.D., Salina

David Nelson, O.D., checks a child's reading speed and print size using an MN Read Card.

Joseph Maino, O.D., assesses a student's ability to read a school worksheet.



Kristina Post, O.D., fits a student with his new distance vision device.

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AMA commits to renewed attacks on Harkin patient access law, optometric standing in eyes of patients and public

After being dealt a series of setbacks on Capitol Hill by optometry, the American Medical Association (AMA) and its medical specialty allies have announced plans for renewed attacks on the landmark Harkin patient access law and a renewed and refocused campaign aimed at undermining optometric education and diminishing ODs in the eyes of patients and the public.

During its annual meeting held in late June, the AMA House of Delegates overwhelmingly approved a resolution calling for the AMA and its medical specialty allies to work together and with other like-minded groups toward full repeal of the Harkin patient access law through aggressive Capitol Hill lobbying and direct outreach to U.S. Department of Health & Human Services' Secretary Kathleen Sebelius and other top agency officials.

The AMA-passed resolution claims that the new Harkin patient access law would effectively limit the ability of health plans to distinguish among varying health care providers. In fact, an AMA spokesperson publicly asserted soon after the approval of the anti-optometry resolution that "before the clause, insurers could have chosen medical doctors over other practitioners or considered their credentials to be of higher quality…"

The AOA-backed Harkin patient access law was opposed by organized medicine and the health insurance industry at each step of the nearly two-year health care reform battle in the nation's capital.

Starting in 2014, this first-ever federal standard of provider non-discrimination will bar health insurers – including Employee Retirement Income Security Act (ERISA) plans – from discriminating against ODs and others in terms of plan coverage and participation.

Through a full mobilization of advocacy resources, the AOA has turned back similar AMA-led schemes opposing hard-won provider non-discrimination safeguards that seek to assure full recognition of optometrists by health plans.

Going forward, the AOA will continue working with pro-optometry partners on Capitol Hill to ensure that pro-access, pro-patient provisions back by AOA and included in the health overhaul law are fully and fairly implemented.

The AMA House also approved a resolution calling for a renewed and refocused effort aimed at enacting so-called "truth in advertising" laws on the state level.

Organized medicine's ongoing campaign to advance such anti-optometry laws have been closely linked to the AMA's Scope of Practice Partnership – a nationwide advocacy campaign aimed at, in part, shrinking optometry's scope of practice and diminishing the profession in the eyes of patient and the public.

The AMA resolution claims that new "truth in advertising" laws are needed on the state level to help "ensure patients are properly informed when making health care decisions."

Similar efforts in the past have focused on uniting doctors of medicine and osteopathy in opposition to the increasing use of optometrists and others in primary care.

An example of such an effort on the national level is "truth and transparency in health care" legislation sponsored by Rep. John Sullivan (R-Okla.) and strongly backed by the AMA and a number of medical specialty societies. However, after being defeated multiple times on Capitol Hill, rebuffed by two leading Washington, D.C., free-market think tanks, and most recently suffering the loss of their lead champion on Capitol Hill on this issue to an AOA-backed primary challenger, the AMA and its allies appear to be abandoning efforts to enact these types of laws on the federal level and may instead be focusing resources on state-level efforts.

The AMA resolution claims that new "truth in advertising" laws are needed on the state level to help "ensure patients are properly informed when making health care decisions."

In fact, despite AMA aggressively backing Rep. Sullivan's push for new FTC controls over how ODs practice and provide care for patients, the group seems to be rethinking their strategy. In response to FTC involvement in an ongoing scope of practice battle in one state, AMA's then-President Peter Carmel, M.D., said in a letter to FTC officials that "it is crucial that licensing boards carry out the responsibilities assigned to them by state legislatures without being intimidated by federal overreach from the FTC."

Nevertheless, the AOA will continue to fight these types of anti-competitive campaigns on the federal level and stands ready to help states vigorously oppose news state-level controls on how ODs practice and provide care for patients.

For more information on AOA advocacy and how you can get involved, including through the AOA Federal Keyperson Program and AOA-PAC, contact the AOA Washington office by calling 800-365-2219 or by email at *ImpactWashingtonDC@aoa.org*.

Vote for the top story of the past 50 years

In reflecting on the gains of the past, be sure to log in to AOAConnect and vote for the top story of the past 50 years at *http://bit.ly/sa18Dn*. Here are some of the top selections of past ways in which the AOA helped strengthen the profession:

1963—AOA became an agency member of the American Public Health Association.
1964—AOA files complaint with U.S. Dept. of Justice alleging restraint of trade and conspiracy on the part of the American Medical Association
1967—Council on Clinical Optometric Care is formed
1968—American Optometric Student Association (AOSA) formed
1970—Alabama legislature authorizes the establishment of a school of optometry, the first to be an integral part of a medical center (UAB)
1971—First DPA Law passed - Rhode Island
1976—First TPA Law passed— West Virginia
1977—U.S. Supreme Court reverses four decades of precedent and holds that professionals may utilize truthful advertising (Bates v. Arizona State)
1986—Medicare parity legislation allows reimbursement for optometrists for health-related services performed on nonaphakic patients.
1988—Federal Trade Commission approves trade regulation (Eyeglasses II)
1994—Publication of first AOA Optometric Clinical Practice Guidelines, providing ODs evidence-based recommendations for patient care
1998—First state law specifically authorizing the use of lasers by optometrists for certain treatment purposes enacted in Oklahoma
2000—Kentucky became the first state to require children to have a vision examination before entering the public school system
2002—AOA launches the Healthy Eyes, Healthy People® program
2005—InfantSEE® program established
2008—AOA establishes the National Commission on Vision and Health (NCVH)
2009—AOA House of Delegates votes in favor of establishing the American Board of Optometry (ABO) to develop and implement the framework for optometric board certification

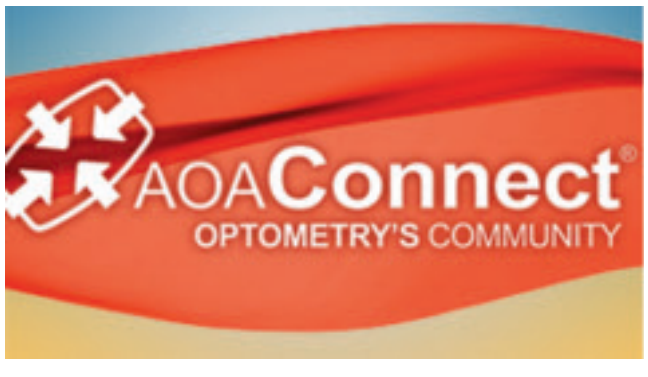
To commemorate 50 years of groundbreaking news in optometry, we will publish the Top 10 *AOA News* stories as selected by our readers from all five decades. Please share your commentary and personal stories on the site as well (*http://connect.aoa.org*). We'd love to hear from you.

Report adverse events involving novelty CLs to FDA, AOA urges

With a growing number of websites and small retailers continuing to illegally offer decorative, non-corrective contact lenses for sale without prescription, optometrists should be diligent in reporting all adverse events associated with such lenses to the U.S. Food & Drug Administration's (FDA) MedWatch Safety Information and Adverse Event Reporting Program, according to the AOA Advocacy Group.

Information may be reported to the FDA's MedWatch program by phone at 800-FDA-1088, by fax at 800-FDA-0178, online at *www.fda.gov/medwatch*, or by mail to 5600 Fishers Lane, Rockville, MD 20852-9787.

AOA Trustee Barbara Horn, O.D., second from left, gets graduating fourth-year students at the University of Missouri at St. Louis (UMSL) College of Optometry pumped up for the next chapter of their careers during the college's annual Senior Seminar. With Dr. Horn, from left, are UMSL's Jennifer Sidun, current American Optometric Student Association national president; Dean Larry Davis, O.D.; and Alan Wegener, past AOSA national vice president.



Developmental vision pioneer Dr. Harold Solan remembered

Harold Solan, O.D., is being remembered as an internationally recognized perceptual vision expert who played a key role in demonstrating, to both educators and health care professionals, the importance of good functional vision in learning and the need for treatment measures to correct developmental vision problems. Over the years, his work has benefited an untold number of children with vision-related learning problems around the world, colleagues say.

Dr. Solan died June 18 at age 90 of pneumonia near his New Jersey home.

"He was a giant in optometry. His research brought functional/development vision to the level it is today," said Irwin Suchoff, O.D., a long-time friend and fellow Distinguished Service Professor Emeritus at the State University of New York State College of Optometry.

Over a career that spanned more than half a century, Dr. Solan published more than 100 peer-reviewed studies and articles demonstrating functional vision to be an important but generally unrecognized factor in academic performance and encouraging vision therapy as an effective means of correcting such functional vision problems. He lectured and conducted workshops around the globe for eye care professionals, educators, and child development experts. He received numerous fellowships, awards and major appointments.

Among his landmark publications was "Vision Therapy Improves Reading Comprehension," a 2003 study in the *Journal of Learning Disabilities* documenting the efficacy of developmental vision therapy in increasing reading ability among sixth graders by improving visual attention and eye movement.

With a diverse multidisciplinary background, Dr. Solan was uniquely qualified to conduct research on functional vision and vision therapy.

A Columbia University Optometry School graduate, Dr. Solan established a private practice specializing in visual training, orthotics, perceptual development and reading improvement – one of the first of its kind. He also began lecturing on orthoptics at his alma mater (1949-1956) while providing optometric or developmental vision services at a variety of institutions around New York City, including the Hebrew Home and Hospital in the Bronx, the Harlem Eye and Ear Hospital, the Reading and Study Skills Center and the Optometric Center of New York.

Joining the SUNY College of Optometry faculty in the 1980s, Dr. Solan became director of the college's Learning Disabilities Unit (1981-1991). He remained in private practice until 1982. He formally joined the college's research program in 1988, allowing him to turn his attention nearly full time to studying developmental vision as well as

spreading the word about vision therapy to both eye care practitioners and educators. He continued to conduct research and education programs on developmental vision until well after his official retirement.

Dr. Solan was inducted into the National Optometry Hall of Fame in 2003. The SUNY State College of Optometry named him a distinguished service professor in 1994. He was a fellow of the American Academy of Optometry and College of Optometrists in Vision Development as well a life member of the AOA.

Dr. Solan and his wife, Shirley, lived in Cliffside Park, N.J.

Call for courses now open!

Optometry's Meeting®
San Diego, Calif.
June 26 – June 30, 2013

The AOA Continuing Education Committee invites submissions of optometric, paraoptometric, and optometric student education courses for the 2013 Optometry's Meeting® in San Diego, Calif. Continuing Education courses will be held Wednesday, June 26 through Sunday, June 30, 2013.

Courses submitted cover a wide variety of ophthalmic topics. All abstracts must be submitted electronically via online submission by Aug. 10, 2012.

To submit a course, visit *www.optometrysmeeting.org*, and click on the "2013 Call for Courses" icon. Inquiries regarding the Call for Courses can be emailed to *continuing-ed@aoa.org*.

Notification of selected courses will be emailed to all applicants in early fall.

It's in the mail!

The AOA and ASCO invited more than 4,000 practicing optometrists to participate in the Optometric Workforce Study survey. When completed later this year, the study will provide the optometric profession, lawmakers and other stakeholders a definitive assessment of supply and demand for eye and vision care in the U.S.

Have you received it?

Participants are asked to respond with completed surveys either by mail or through the weblink provided in the mailing by July 31.

For additional information on the study, see http://bit.ly/Mar0Wj.

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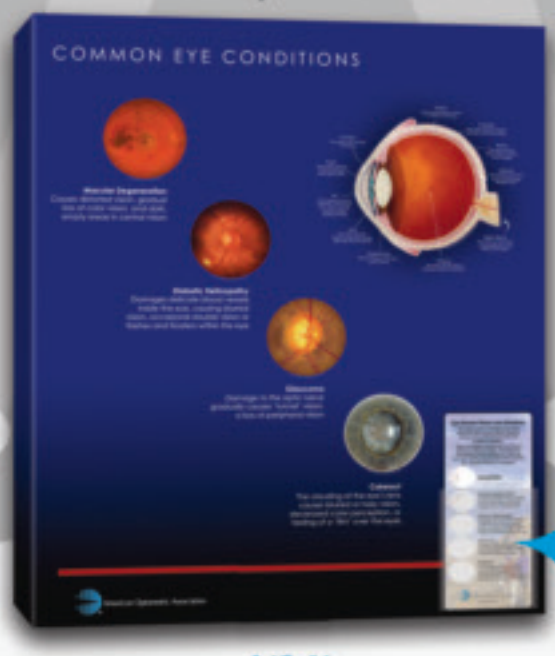
Common Eye Conditions



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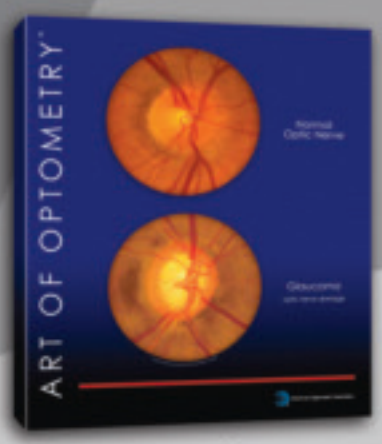
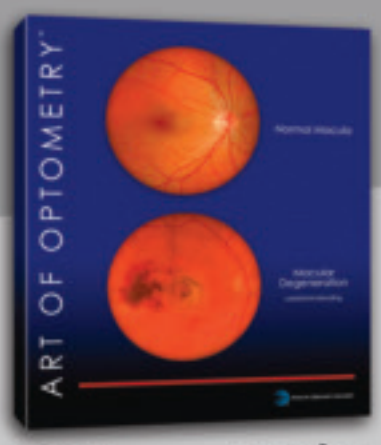
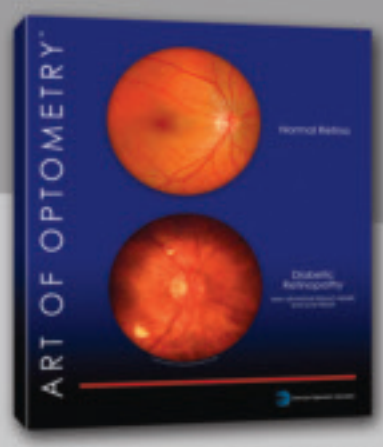


GP-5 *Glaucoma*

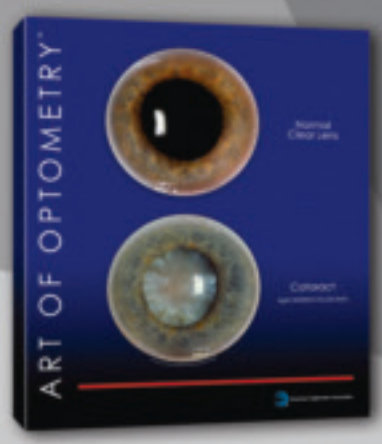


GP-6 *Macular Degeneration*

GP-9 *The Human Eye*



GP-7 *Diabetic Retinopathy*



GP-8 *Cataract*

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SCO program aims to increase minority interest in optometry

Last month, 12 Memphis high school students descended on Southern College of Optometry's academic and clinical spaces for the first-ever "Success in Sight," a two-day intensive summer learning opportunity for at-risk minority students.

"The prevailing trend among most of our graduates is to return to their hometowns to practice optometry," said Janette Dumas, O.D., coordinator for minority student recruitment at SCO. "While our geographically diverse enrollment is beneficial to most areas, the relatively low number of minorities in the field of optometry as a whole leaves many inner cities without necessary eye care professionals."

"While our geographically diverse enrollment is beneficial to most areas, the relatively low number of minorities in the field of optometry as a whole leaves many inner cities without necessary eye care professionals."

Dr. Dumas hopes to change that as an assistant professor and optometrist at SCO.

She sought to combat the trend by reaching out to area high school counselors in Memphis, Tenn., where SCO treats more than 80,000 patients per year through The Eye Center.

The goal was to reach students with an interest in health care and the potential to fulfill a great need in their communities, and the counselors quickly jumped on board.

This year, Dr. Dumas welcomed 12 students to the inaugural program from Central High School, Memphis Health Careers Academy and the Memphis Academy of Health Sciences.

During their two-day visit to the school, the students met with optometrists in both academic and clinical settings and took part in various activities, including dissections and eye exams.

"Our students are interested in health care, but few know what it takes to get there or what the options are," said Jada Meeks, Ph.D., counselor at Memphis Academy of Health Sciences. "It's easy to watch television and have an idea of what a surgeon does, but optometry is a viable career path that is not often highlighted in the mainstream media. This program is going to be so beneficial to our students and the underserved communities in which they will eventually practice."

While 2012 marks the first year of Success in Sight, Dr. Dumas hopes to expand it and eventually create a program that can be replicated at optometry schools and even private clinics across the country.

"The patients we serve at The Eye Center at SCO really inspired me to build this program and help minority communities overcome a lack of health care professionals," Dr. Dumas said. "The participants were wonderful, and I hope to see them as students in my classroom in the next few years."

Zakiya Nicks, O.D., an SCO faculty member, instructs students in the "Success for Sight" summer learning program.

Coordinator for minority student recruitment at SCO Janette Dumas, O.D., is shown with program participants. Dr. Dumas hopes to expand the program for at-risk students to other schools across the country.

SCO student Virgilio Gozum demonstrates procedures to students as part of the program.

House honors Keefer's work for InfantSEE®, profession

The AOA House of Delegates passed two resolutions at Optometry's Meeting® last month recognizing The Vision Care Institute™ President Phil Keefer's contribution to the AOA and Optometry Cares®-the AOA Foundation InfantSEE® program.

as the first line of vision care."

Keefer was influential in drumming up support for the program and helping it reach a critical mass of volunteers so it could have a solid foundation upon which to build.

"My hope is that the numbers of InfantSEE® volunteers will continue to grow,

He thought it was a great idea for patients and also saw InfantSEE® as "a huge opportunity for optometry to be recognized by the general public as the first line of vision care."

Following a distinguished 23-year career with Johnson & Johnson Vision Care and more than 40 years in the eye care industry, Keefer announced his decision to retire, effective Sept. 1, 2012.

"Mr. Keefer was a stalwart supporter of optometry and the ophthalmic industry at various companies, including Allergan, CooperVision, Optical Radiation Corporation and Polymer Technology," one resolution reads. "Mr. Keefer was instrumental in providing initial and ongoing funding from The Vision Care Institute™, a Johnson & Johnson company for InfantSEE®; and... Mr. Keefer guided the development of InfantSEE®, which has resulted in the free comprehensive vision assessments for countless thousands of babies ages 6 to 12 months."

Keefer said he first heard about the idea for InfantSEE® from past AOA presidents Pat Cummings, O.D., and Vic Connors, O.D., more than a decade ago. "Without them even asking, I said how about Vistakon as a sponsor?" he recalled.

He thought it was a great idea for patients and also saw InfantSEE® as "a huge opportunity for optometry to be recognized by the general public but even more so than that is for the AOA to take a very proactive stance to get the word out to the public," said Keefer.

Keefer joined Johnson & Johnson Vision Care in 1989 as executive vice president of sales, marketing, professional affairs and strategic planning, where he oversaw the initial launch of the Acuvue® Brand and helped grow the product line to its current leadership position. In 1993, Keefer was appointed vice president, new business development, where he created and implemented global strategic plans that included the international expansion of the vision care franchise. He served as managing director/president of multiple regions, including Asia Pacific, the Americas, Latin America and Japan.

Keefer is currently president of The Vision Care Institute, where he conceived and implemented a professional education strategy that resulted in the creation of 15 Vision Care Institutes and nine satellite centers around the world. He has also served as an active member of the Johnson & Johnson Vision Care Global Management Board for his entire 23-year career.

In addition to his job responsibilities, Keefer chaired the Contact Lens Institute Board of Governors and also served on several boards, including the American Optometric Foundation, VisionWeb, Inc., the National Boards of The Vision Council of America and Prevent Blindness America, and the Florida Board of Prevent Blindness America.

In 2009, the American Academy of Optometry presented Keefer with the Honorary Fellowship Award for his distinguished contributions to the science and art of optometry.

Before joining Johnson & Johnson in 1989, Keefer held positions of increasing responsibility across multiple eye care companies, including Allergan, CooperVision, Optical Radiation Corporation and Polymer Technology Corporation, where he was instrumental in taking the company from start up to global distribution and worldwide success.

The Vision Care Institute President Phil Keefer, at left, is shown with InfantSEE® Committee Chair Glen Steele, O.D., at a reception for Keefer at Optometry's Meeting®.

Keefer said he was humbled by the unexpected recognition by the AOA and views it as a lifetime achievement honor. "I've always believed you do the right thing and good things will happen."

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EyeLearn™ course spotlight

SUN Part 1-Protect offers ways to explain UV dangers

Sunglass sales are increasing faster than other vision care products and services, noted John Lahr, O.D., the instructor for the SUN Education Series on the AOA EyeLearn™ optometric continuing education portal. Sales of sunglasses were up 4.5 percent from 2010 to 2011, compared with a 2.8 percent increase for other segments of the vision care market, according to data compiled by the industry tracking service Vision Watch.

He believes it is because eye care professionals are failing to adequately educate the public about the danger UV radiation poses to the eye.

He also believes the most effective form of education is one-on-one consultation with patients in the examination room.

"You know the risks, but do your patients?" asks Dr. Lahr.

Some 91 percent of patients report awareness that UV is damaging to their eyes, according to to them," Dr. Lahr maintains.

In SUN Part 1 – Protect, the first in a series of three COPE-approved optometric continuing education courses on UV protection being posted on Eyelearn™ this year, Dr. Lahr outlines his methodology for helping patients understand the dangers of UV.

The course summarizes information that optometrists can easily provide patients on UV and high-energy visible (HEV)

"Patients generally perceive UV damage to their eyes as "some future distant thing that might possibly happen."

However, bronzing lotions and artificial tanning sprays are up a projected 18.1 percent this year, according to a new report by the marketing research firm IBIS World, with sales expected to double over the next five years, making such products one of America's 10 fastest growing industries.

In the case of both alternative tanning products and sunglasses, the increases come in large part as a result of growing concern over the harmful effects of ultraviolet (UV) radiation, the marketing research finds.

Given considerable research showing that people value eyesight more than any other sense, and the longstanding status of sunglasses as a fashion accessory, why aren't sunglass sales increasing as fast as products designed to protect the skin from UV, Dr. Lahr asked.

results of Jobson Optical Research Surveys and the AOA's American Eye-Q™ surveys. However fewer than one-third can identify eye conditions resulting from UV.

Only about half (48 percent) of patients say their eye doctors have talked to them about the dangers of UV, the surveys find.

Patients generally perceive UV damage to their eyes as "some future distant thing that might possibly happen," Dr. Lahr said.

The Jobson research finds 79 percent of patients expect to receive an oral summary of findings, in layman's language, during an eye examination, Dr. Lahr noted. However, Dr. Lahr believes relatively few eye care practitioners provide a simple layman's explanation of the effects of UV radiation during patient visits.

"Patients need to see that sun protection is vital

radiation-related eye conditions such as age-related macular degeneration and cataract. While the course emphasizes providing UV education for all patients, Dr. Lahr notes optometrists should be particularly diligent in providing such counseling to high-risk patients.

Men with higher levels of UVB exposure are 1.36 times more likely to develop cortical cataracts, studies show. Male smokers were 3.29 times more likely and female smokers were 2.50 times more likely to have exudative macular degeneration.

The widely cited Chesapeake Bay Waterman Study found men with double the exposure to UVB had a 60 percent increased prevalence of cortical cataracts. Farmers exposed to UV had significant eyelid and conjunctival pathologies compared to controls, the study found.

The course also provides useful tips optometrists can provide to patients on avoiding harmful UV. Skin exposure to UV is generally greatest from 10 a.m. to 2 p.m. while ocular surfaces are generally most exposed to UV from 8 a.m. to 10 a.m. and 2 p.m. to 4 p.m. The course also covers easy ways to help patients meaningfully understand how UV can damage eye tissue and why it poses at least as great a danger to the eyes as to skin.

"The cornea is like skin. The outer layer is the fast growing, made up of easily regenerated epithelial cells. It has the same UV burning susceptibility as skin epithelium," Dr. Lahr noted.

Launched this past spring (see *AOA News*, June) the SUN project advocates a three-step program under which optometrists educate patients on the importance of UV protection, prescribe properly protective eyewear and then provide it in the dispensary. By taking all three steps in the course of one patient visit, Dr. Lahr believes eye care practitioners can be highly effective in protecting their patients from the effects of UV radiation. A concerted effort to protect patients from the effects of UV radiation is essential now to help curb a projected upsurge in age-related eye conditions over the coming decades, Dr. Lahr believes.

The SUN Education Series, like all AOA EyeLearn™ courses, is available free of charge to AOA members. Certificates will be issued to those who successfully complete all three of the series modules. AOA members can access the EyeLearn™ education portal at *www.aoa.org/eyelearn*.

3-D symposium offers real-world applications for ODs

The 3-D Education Symposium showcased at Optometry's Meeting® was designed to help attendees better understand current 3-D technology along with the diagnostic and therapeutic strategies for managing patients with 3-D vision-related symptoms.

Featuring the science behind stereoscopic 3-D is an essential step to increased understanding of 3-D and stereoscopic 3-D (S3-D) viewing as a safe and appropriate technology for all audiences. As the popularity of 3-D rises, so too will optometry's responsibility to educate the public and assist the production studios and other 3-D developments.

With the planned comprehensive education, optometric professionals had the opportunity to take a journey through the entire process of 3-D, plus experience the first-ever live, heads-up 3-D slit lamp demonstration thanks to TrueVision's support. Anthony Lopez, a third-year UMSL student, was fortunate to be the "first-ever optometry student" to experience a slit lamp exam using this new 3-D technology.

The depth perception people see in 3-D movies, television, video games and in classroom education are different than that experienced in the real world. Some viewers have symptoms of eyestrain, blur, diplopia and vertigo while viewing 3-D; others are unable to appreciate the stereoscopic depth.

This course lecture panel included James Sheedy, O.D., Ph.D.; Michael Duenas, O.D., Dominick Maino, O.D.; Donna Matthews, O.D.; Phil Corriveau from Intel Labs; and Len Scrogan, a 3-D educator.

The 3-D Symposium panel included, from left, Jim Sheedy, O.D., Ph.D., Shannon (a patient of Dominick Maino, O.D.), Dr. Maino, Donna Matthews, O.D., Michael Duenas, O.D., Phil Corriveau and Len Scrogan.

The panel described how simulated 3-D compares to the real world and provided a framework for understanding the difficulties some patients experience.

The panel also offered diagnostic, therapeutic and public health strategies for improving binocular vision on a broad scale in the U.S.

As one in four individuals may have a vision problem that interferes with being able to enjoy the 3-D experience, this is rapidly becoming a major public health issue and opportunity, said Dr. Duenas.

AOA Member Benefits

VisionWeb offers members tools for running modern billing departments – Are you using them?

While many practices may be stuck in the habit of going to multiple sites to manage claims, modern billing departments are embracing the use of clearinghouses and all the efficiency that comes with them. As a practice owner, you need to make sure your staff has the tools and knowledge to run an efficient modern practice. Take a look at what modern practices are doing to get the most out of their claim filing processes.

They take advantage of centralized claim filing

Is your billing department racing across multiple websites to file claims? There is a better way. A clearinghouse, like VisionWeb, is the go-to solution that allows modern practices to check patient eligibility, submit and track claims, and process secondary claims with all of their payers – all in one location! How easy is that?

They have a handle on reporting, analytics

Modern practices know more than just "Paid" or "Rejected" for claims. They are able to keep a close eye on their claims through detailed reporting and analytics that cover all aspects of claims including the number of claims that have been rejected vs. accepted, top payers that are rejecting claims, timeline of claim submission for tracking, and top rejection reasons.

They put their practice management system to work

Practice management software is a significant investment for any practice, and it's important to get the most for your money. Modern practices put their practice management systems to work and utilize all their capabilities to create batch claim files directly within the system, upload the batch claims and submit directly to payers, and reduce the redundancies associated with rekeying claims.

They utilize electronic remittance advice (ERA)

Paper explanations of benefits (EOBs) are a thing of the past! ERAs simplify the reconciliation and secondary claim filing processes by providing remittance information in a searchable and electronic format, makes it easy to search remits by payer, amount, date, patient, or provider, and gives users the ability to print only the information needed for secondary filing.

How do modern practices do all this? Here at VisionWeb, efficiency and productivity through technology is our specialty, and we know a modern practice when we see one. Don't let your practice fall behind! As part of the AOA's Member Advantage team, VisionWeb is dedicated to providing complete electronic claim filing solutions that AOA members can rely on, at a cost that every practice can afford.

AOA members who enroll with VisionWeb as new customers will receive $0 enrollment fees and 15 percent off monthly fees – an instant savings of $370! (Practices already filing claims with VisionWeb are eligible for the 15 percent monthly fee discount.) These offers are available exclusively for AOA members! Contact a VisionWeb enrollment consultant at 800-590-0873 or *sales@visionweb.com* to learn more or enroll and be sure to mention your AOA membership!

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'Ask the Codeheads'

Implementing the 'medical model' in your practice

Edited by Chuck Brownlow, O.D., Medical Records consultant

There has been a lot said and much written lately about the "medical model" of eye care delivery. Of course I've listened and read much on the subject, but I must admit I'm a little confused. As I pondered whether there actually is a difference between a "medical model" for eye care and a "non-medical model" or a "routine model," I decided to think about other health care providers and whether I could detect a swing in their mode of operation into some new "medical model." Somewhat to my surprise, I have seen a change in health care delivery, so I'll review that with you to see if it may shed light on this concentration on the appropriateness of the "medical model."

The influence of coding

Local physicians seem to change the way they deliver care after they sell their practices to large regional clinics. I've noticed they spend more time asking questions, many of which don't seem to be at all related to the reason I'm in their office, with the questions often almost scripted.

This is much different than the older "model" used by the same physicians, so I'm thinking maybe this is part of the new "medical model." I've even had physicians, nurses, advance practice nurses, physician assistants, and other personnel apologize during the case history, even making comments such as "I'm sorry for all these questions, but our certified professional coders say we'll get in trouble if we don't ask at least four questions in this section."

Mmmm. Maybe this is what they're talking about when they refer to the "medical model."

The influence of EHRs

In my visits to those same health care providers I've noticed they don't spend much time actually looking at me or even touching me… Their hands and eyes are pretty much devoted to "hunt and peck," typing lots of words and numbers into a keyboard, while looking back and forth, fingers to monitor, very much like that dog that played piano on the old Muppets TV show.

I even interrupted a doctor one time as he was struggling with data entry to ask him if he had noticed I had developed a tendency to drag one foot while walking, or that one side of my face doesn't seem to move any more when I smile or talk, or that the "whites of my eyes" seemed pretty yellow lately. Needless to say, he took a real good look at me right away before returning to his data entry, this time accompanied by some mumbling about "health care would be a lot better if we didn't have to pay attention to the lousy patients."

I've even spoken with health care providers who are very excited about their clinics' new electronic medical records. One doctor swung the monitor around so I could see the red flags on the screen indicating he could not grade as high as he wanted unless he went back and did at least two more tests… The computer even told him which tests to do. I thought that was up to the doctor's professional judgment, based on my needs. Don't worry, though, he did go back and do the extra tests, so his coding choices were fine. Mmmmm. Maybe this is what they're talking about when they refer to the "medical model."

The influence of local coverage determinations, software, CE

I overheard a colleague discussing her protocols for dealing with primary open-angle glaucoma. It seems she discovered the local coverage determination for her Medicare carrier included lists of procedure codes that are paid when billed with the diagnosis code for open-angle glaucoma.

She was very excited about this because it meant she could do four, five, even six different procedures each time her glaucoma patients came in for their quarterly check-ups. She was giddy in describing the positive impact on her gross and net revenues.

Mmmmmmm. The "medical model," I'll bet.

The influence of audits by Medicare, other insurers

Over the past several months I've learned of quite a few optometrists being audited by Medicare and other insurers. Some have been surprised auditors are checking to be sure the care provided for the patient is related to the reason for visit recorded at the top of the chart and the resulting diagnoses recorded at the bottom of the chart.

Some of the auditors demand repayment for office visits and/or procedures that are coded improperly, with no clear relationship between the content of the record and the Current

See Codeheads, page 37

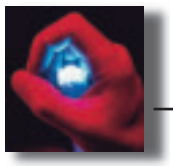
AOA Medical Records and Coding Resources

The following resources are available to AOA members through AOAExcel. Visit *www.ExcelOD.com*.

- "Frequently Asked Questions" for members-only provide detailed answers to medical records and coding questions.
- AskTheCodingExperts@AOA.org offers AOA members the opportunity to email their coding questions and have them answered by a topical expert in medical records and coding.
- Medical Records and Coding Webinars are provided as a no-cost AOA member-only benefit to educate doctors and staff on medical record-keeping and coding.
- The AOAConnect social networking site features a Coding & Billing Group where AOA members, students, volunteers and staff can share information that specifically relates to coding and billing (*connect.aoa.org*).
- AOACodingToday.com is an AOA member-only benefit available to all AOA members at no cost (previously $349). AOACodingToday.com is a Web-based resource for information related to procedure and diagnosis codes, national and local coverage rules, and Medicare relative value information.
- AOA.ReimbursementPlus.com Suite, a customized version of the industry-leading CPT Data & Information Service, ReimbursementPlus® is the leading cloud-based service for any information related to procedure and diagnosis codes, fee analysis, Centers for Medicare & Medicaid Services (CMS) reimbursements, national and located coverage rules, CCI edits and any other CPT information desired, all specific to the practitioner's ZIP code. *AOA.ReimbursementPlus. com* provides critical real-time information that will greatly benefit AOA members in medical coding and compliance within their eye care practices.
- Codes for Optometry is provided by the AOA's Order Department for $140. It is a two-volume set including Current Procedural Terminology© American Medical Associaiton codes and a separate volume of diagnosis codes used in eye care, Medicare's Correct Coding Initiative, the HCPCS codes for reporting materials in Medicare, and the Documentation Guidelines for the Evaluation and Management Services. Codes for Optometry is available on a CD in a searchable format.

The AOA is devoted to assisting members in dealing with the challenges of everyday practice life, including those related to insurance programs.

The AOA is excited to bring this expertise directly to members' offices as a value-added member beneift. Many of these benefits are provided at no cost or at greatly reduced cost to AOA members.



Health care portals: A patient's connection to your EHR

By Geoffrey G. Goodfellow, O.D., and Dominick M. Maino, O.D.

An important component of an effective electronic health record (EHR) system is a patient portal.

A portal is a Web interface to related sets of data, content, or Web services.

Google is one of the most well-known portals that aggregates information into one place.

What is a patient portal?

A patient portal is a digital interface that allows a patient to interact specifically with his/her health care information.

Patient portals can enable a patient to complete one or more of the following:

- Request or check a health care provider's appointment schedule
- Complete new patient intake or case history forms prior to the office visit
- Access his/her health records including lab or test results
- View account balances, download statements, or make payments related to their health care
- View the status of optical and contact lens orders
- Request a pharmaceutical prescription refill
- Receive electronic messages from health care providers such as appointment reminders, billing statements, or lab results
- Submit electronic messages to a health care provider or initiate a virtual office visit with chat or video conferencing.

Patient portals could be accessed with a traditional desktop or laptop, a tablet computer, or even a smartphone.

Patients gain access to the portal by using the Internet to connect to a specific Web address.

Most often, this can be a hyperlink directly from the practice's main webpage.

For security, the patient logs in using a secure username and password. Secure portals should exchange data in a Health Insurance Portability and Accountability Act (HIPAA)-compliant manner that involves data encryption.

Most patient portals give authority to the provider to share only the data that he/she wishes the patient to see. The provider notes are protected.

A patient portal is a digital interface that allows a patient to interact specifically with his/her health care information.

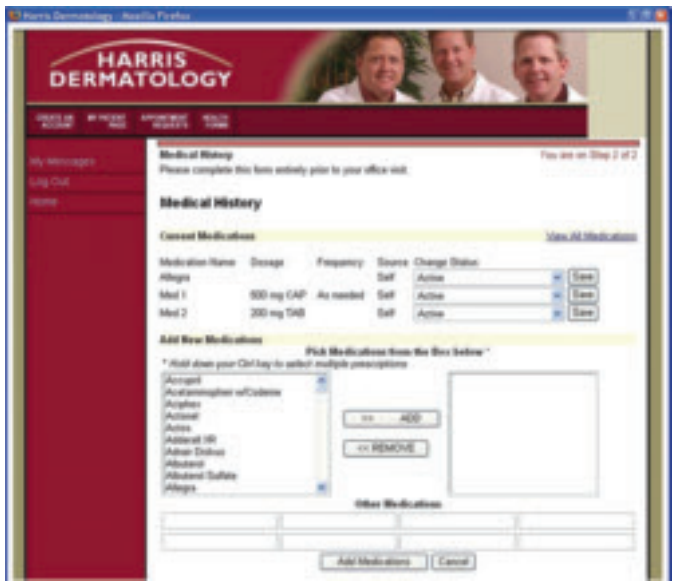
The information itself doesn't actually reside in the portal; instead, the portal is merely a gateway to connect the patient to data that are stored in the EHR or practice management systems.

Sending health care information through patient email is not secure.

However, the practice can still use familiar tools like email and text messaging to alert patients that there is secured information available in the patient portal that needs their attention.

Advantages of patient portals

- Minimizes office waiting time while patients fill out paper forms.
- Some systems provide information in multiple languages with automatic translation built in.
- Unlike a telephone conversation or email, all correspondence between provider and patient with the patient portal is automatically archived with the patient's record.
- Health care providers can deal with fewer mundane tasks and are able to provide care to more patients.
- Studies indicate that providers tend to improve their EHR documentation when they know it will be reviewed by patients online in a patient portal.
- Patients and families are able to feel more connected and in control of their health care. A recent survey found that patients, particularly those with lower incomes, pay more attention to their health when they have efficient access to their online health information.
- A patient portal is the most cost effective and patient service oriented strategy to fulfill some of the meaningful use core measures.



To ease the transition for patients, many of the online Web forms can be made to look similar to traditional paper forms.

- Portals have the potential to improve the management of chronic disease.

For example, patients who actively engage with the patient portal to record their glucose, blood pressure, and physical activity may monitor these values and make better lifestyle choices on a daily basis rather than just at times in close proximity to a doctor's visit.

Disadvantages of patient portals

- Some patients may not have access to an Internet-enabled device. In these cases, a touch-screen kiosk or tablet could be provided in the patient reception area. To ease the transition for patients, many of the online Web forms can be made to look similar to traditional paper forms.
- Not all patient portal systems are the same. Some offer more features than others or may have different levels of meaningful use compliance. Patients are already familiar with portals from banking, insurance, and other businesses, so their expectations for a health portal are often very high.
- There are purchasing and implementation expenses to establish an EHR system with a patient portal.
- There can also be resistance to changing the practice work flow and retraining staff to interact with a patient portal.
- Although the technical details for patient portal data security lies with the EHR provider and not the health care provider, there is still a concern by some patients about having their personal health information available online.

How do patient portals impact optometry?

Under the meaningful use provisions included in the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, in Stage 1, patient portals are simply a convenience for delivering to patients the required clinical summaries of office visits.

However, in Stage 2, for which details have not yet been published, a patient por-

See Portals, page 36

The Art of Optometry

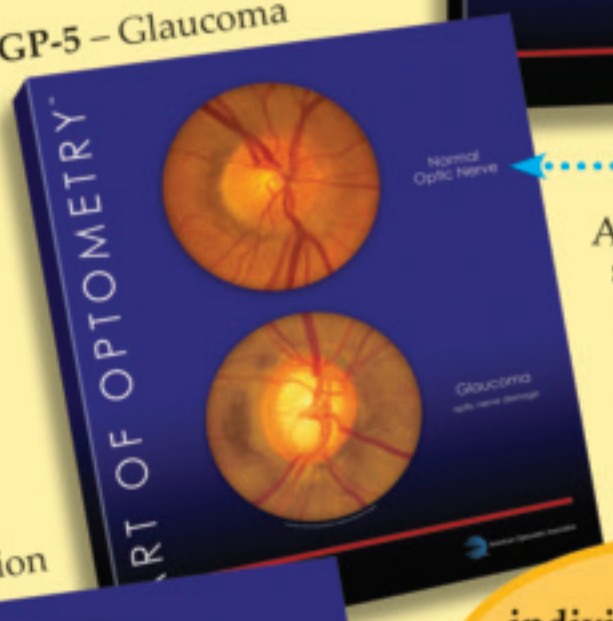
Educate patients with five, eye-catching diagnostic visuals

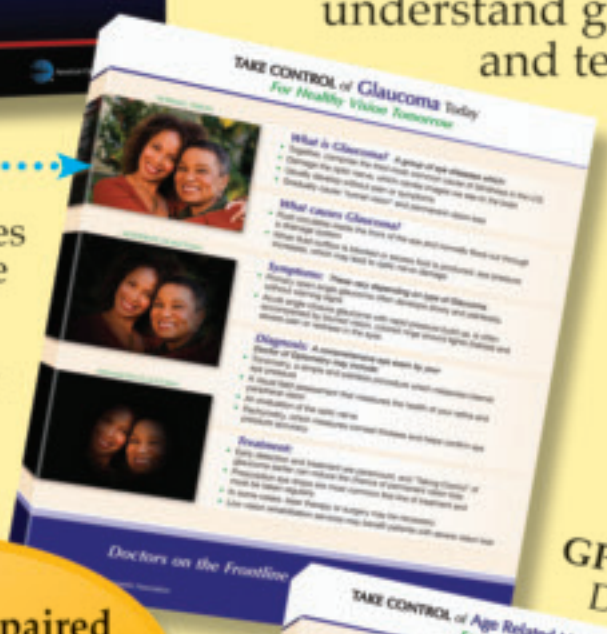
GP-9 –
The Human Eye

In Focus

Professional, easy-to-understand graphics and text

GP-5 – Glaucoma

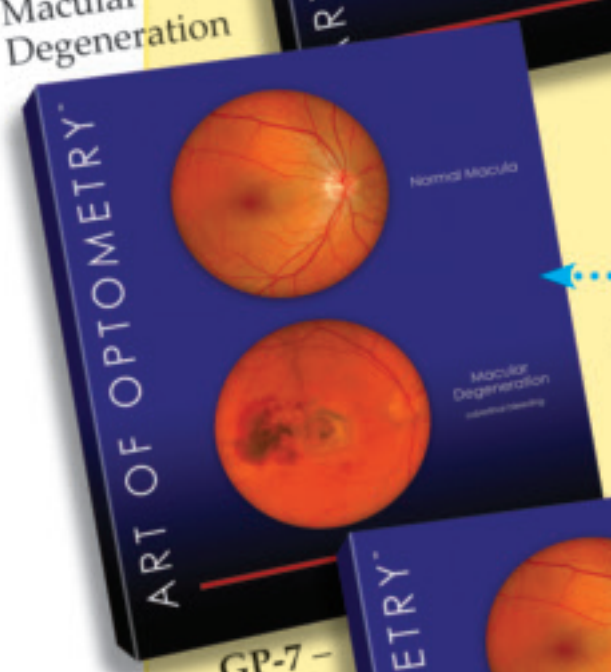




GP-1 –
Glaucoma

All canvases shown are 20"x 24"; NO *additional framing required.*

GP-6 –
Macular Degeneration



Display individually *or* paired with each corresponding canvas *($178 Per Pair)*

GP-2 – Macular Degeneration

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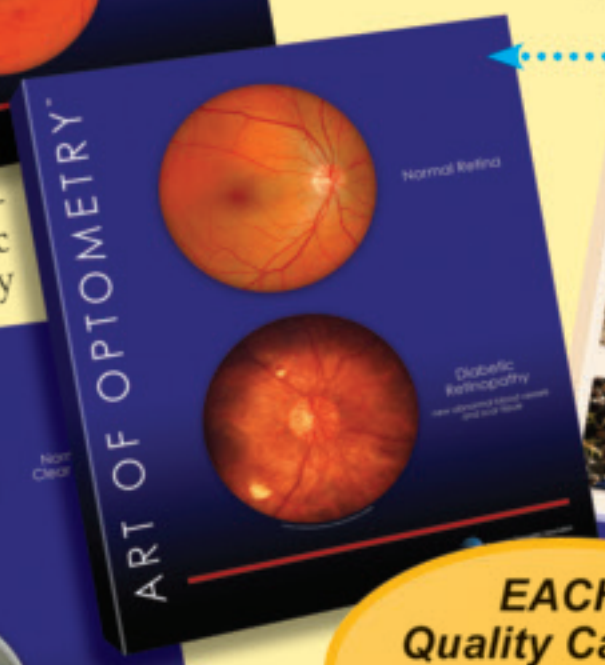
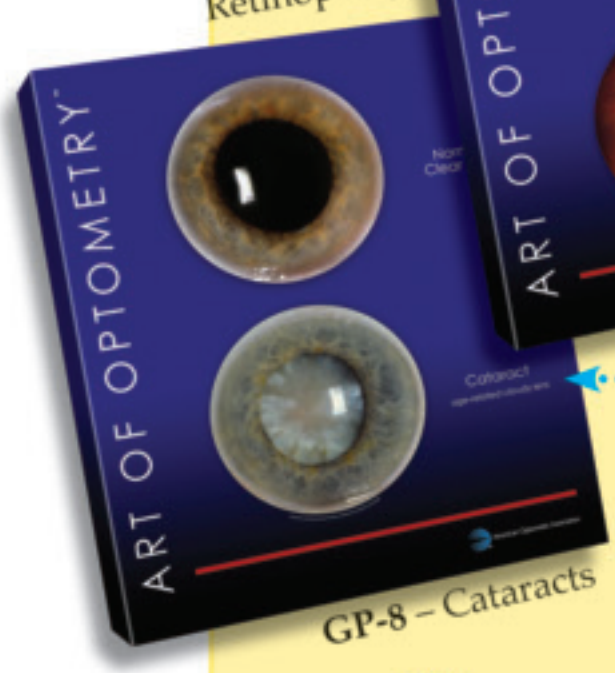
GP-7 –
Diabetic Retinopathy



GP-3 –
Diabetic Retinopathy



GP-8 – Cataracts

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GP-4 – Cataracts

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American Optometric Association

Check out Practice Strategies, a popular section of Optometry, now in the AOA News, with expanded content and timely resources.

Sports concussions raise new awareness of mTBI care

By Maria Richman, O.D., and Jack Richman, O.D., AOA Vision Rehabilitation Section

The risk of concussion has been the subject of increasing attention in the world of sports and in the media over recent years. As students head back to school this fall, the topic of sports-related concussion and head injury will probably be back in the news again.

The Centers for Disease Control and Prevention (CDC) estimated that each year approximately 1.5 million people survive a traumatic brain injury (TBI), among whom approximately 230,000 are hospitalized. It is estimated that of the total reported TBIs, the vast majority (75 – 90 percent) of these fit the categorization of mild TBI (mTBI) or concussions. Many of those concussions are sports-related.

The emergence of sports-related concussion as a high-profile health issue has focused unprecedented attention on a subject optometrists have been trying to bring to greater public awareness for years: the ocular manifestations of mTBI and the potential use of vision tests in screening for such injury.

For that reason, practicing optometrists should not be surprised to get some questions regarding the dangers of concussion from patients who are athletes, or the parents of young athletes. Moreover, they should consider how this new awareness of the dangers of sports-related concussion is creating a number of opportunities to serve their patients and communities.

Practitioners should consider asking about sports participation on their patient histories and counseling patient-athletes appropriately. In some cases, the growing awareness of concussion and its visual manifestations may present opportunities for optometrists to conduct public education through local sports organizations. Such outreach can be highly effective in establishing an optometrist as a full-scope provider of a complete range of primary eye and vision care services. It can also provide an excellent opportunity to provide public education on a range of eye and vision care topics.

An audience that is already concerned about sports-related concussion may be interested in information regarding mTBI in the work place or the importance of eye examinations for military veterans who may have sustained battle-related brain trauma. They may be receptive to information on the importance of impact-resistant eyewear or ultraviolet (UV) protection for athletes. They may also be interested to learn how sports vision training can benefit athletes or, perhaps most importantly, how similar vision training could benefit underperforming students in the classroom.

The AOA Vision Rehabilitation Section is now preparing a comprehensive, optometric brain injury manual, covering the diagnosis and treatment of the ocular manifestations of mTBI in a variety of settings, including sports and veterans care. The manual is written for the primary care optometrist, with the intent of reviewing the skill sets and knowledge base all ODs acquired through optometric curriculums, which are pertinent to the assessment and treatment of the patients with mTBI. In addition, we will offer advice on participating on an interdisciplinary team, patient counseling and an extensive bibliography of pertinent research. It is scheduled for release later this year.

More than 90 percent of sports-related head injuries result in no observable loss of consciousness.

In the meantime, as the fall sports season nears, here are some of basics that optometrists may wish to keep in mind as they consider how they can best provide care for mTBI patients in their practices, answer patient questions, or provide public education.

Testing options

Concussions are a form of traumatic head injury that can occur from both mild and severe blows to the head. Some head injuries may appear to be quite mild but research reveals that concussions can have serious, long-term effects, especially with repeated head injuries.

Concussions have been studied and discussed for decades by a range of health care professionals including pediatricians, neurologists, and optometrists, as well as by athletic trainers, coaches, and others in the sports community.

Detecting concussion is relatively straightforward when a person is unconscious or clearly disoriented. However, more than 90 percent of sports-related head injuries result in no observable loss of consciousness. The use of neuropsychological testing for the assessment of sport concussion has rapidly grown in the United States since its introduction to the sports medicine community.

Recent efforts have focused on the development of brief screening and diagnostic tests that can be used at the site of the sports activity.

One such test, Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT), is one of the most-widely used and validated computerized concussion evaluation systems. Developed more than 20 years ago, it is a brief 20-minute test that can be administered by medical and/or sports personnel who are trained in the use of ImPACT.

Another assessment tool that has been used for years to quickly assess effects of a concussion is the Standardized Assessment of Concussion (SAC). This SAC test takes about five to 10 minutes to administer and includes measures of orientation, immediate memory, concentration and delayed recall. It also includes a brief neurological screening.

Despite the advantages of computerized neuropsychological testing (e.g., ImPACT) and non-computerized screening (e.g., SAC), these tests can play only a limited role in the initial diagnosis of concussion because the diagnosis must occur on the playing field at the time of injury. This limitation is most important when considering the needs of high-school age and younger athletes, who have fewer available sport-related health care resources than collegiate and professional athletes, but represent the largest share of sports related concussion each year. Some 65 percent of sport-related concussions occur in those age 5 to 18 years. Therefore, what are needed in addition to the well established neuropsychological tests are simple, accurate, inexpensive clinical measures that may serve as initial screening tools on-site by sports personnel.

One such very low cost test is a clinical reaction time (RT) test, developed at the University of Michigan, Ann Arbor, which can be administered on the sideline or in the training room at the time of injury. In fact, clinical reaction time on a device was both positively correlated with and more consistent than reaction time obtained via computerized testing. Clinical reaction time assessment may become a new tool in a comprehensive approach to diagnose concussion in athletes. Another rapid test that is vision based has been widely reported in the news. The two-minute test tracks subtle vision problems in athletes with suspected traumatic brain injury. The test, called King-Devick (K-D), is based on the saccadic eye movements that allow the eyes to focus on specific spots. As every optometrist knows, a problem with the eyes' ability to track and focus suggests impairment involving brain pathways. With the K-D test, a person reads rows of single-digit numbers arrayed on a page. Some numbers appear in a straight line from left-to-right, whereas others appear staggered. The time it takes a person to recite the numbers after a head trauma may provide insight into whether he or she suffered a concussion. In a study, published in the journal *Neurology*, the K-D test was administered to a group of 39 boxers and mixed martial artists before a sparring match. After a nine-

See mTBI, page 38

AOA Paraoptometric Section expands education offerings

Staff can advance their careers and enhance their skills with the AOA Paraoptometric Section's new education series, New Horizons for Paraoptometrics.

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Call 800-365-2219, ext. 4108 for more information.

Kentucky,

from page 15

deny patients access to care or result in any increased patient costs for covered health services," Eakin said.

"Pure" discount programs that offer enrollees reduced prices on health care goods and services from participating practitioners, rather than a benefit package of covered services, will still be available in the state and will not be affected by the new law, Eakin noted.

"Although dentistry has been pursuing this type of legislation for several years, this is the first such victory for optometry, and is an important win in our battle for non-discrimination," said Bobby Jarrell, O.D., AOA-SGRC chair. "It is basically a law that prohibits insurance companies from capping or discounting fees for those services that are not covered by the insurance. We feel like this really makes sense for all ODs who run their businesses in a free-market economy. We have been encouraging the states to pursue this type of legislation, and hopefully the victory in Kentucky will motivate other affiliates across the country."

For additional information on NCS fee capping legislation or other state legislative issues contact the AOA SGRC at *SLCooper@aoa.org* or *Breuwer@aoa.org*.

Portal,

from page 33

tal will likely be a necessity.

All providers will need to demonstrate:

- Timely electronic access to changes in health information
- Electronic copies of health records
- Clinical summaries of office visits
- Patient-specific education resources.

In short, a patient portal system of one form or another can save providers a tremendous amount of money on staff time, printing costs, and mailing costs in meeting some of these meaningful use measures.

As for the "timely electronic access to changes in health information" measure, providers will likely need to utilize a patient portal specifically.

Recent research shows 73 percent of consumers would use a patient portal to help them pay their health care bills, communicate with providers, make appointments, and obtain lab results.

Patients are demanding increased health information technology.

Optometry is a significant player in health care, and the patient portal will surely be an important component in all of our practices.

Dr. Goodfellow is an associate professor of optometry at the Illinois College of Optometry (ICO) and the college's assistant dean for curriculum and assessment. He can be contacted at ggoodfel@ico.edu. *Dr. Maino is a professor of pediatrics and binocluar vision at ICO and a recipient of the Leonardo da Vinci Award of Excellence in Medicine. He can be contacted at* dmaino@ico.edu.

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N.M. OD helps others see through the smoke

The primary goal of Terry Marquardt, O.D., and his practice in Alamogordo, N.M., is to improve the quality of life of patients. So when the Little Bear wildfire sprung to life in the Lincoln National Forest last month, Marquardt Eye Associates put that goal into action.

Local news agencies estimate more than 1,300 firefighters and support personnel were on the scene fighting the hard-to-contain blaze.

High winds and hot temperatures added even more challenges to the job, leaving responders' eyes red and irritated from the smoke.

A staff member at Marquardt Eye Associates heard an advertisement on a local radio station seeking donations for those impacted by the wildfire. Both victims and firefighters were in need of food, water, blankets and eyedrops.

This inspired the staffer, who prefers to remain anonymous, to ask Dr. Marquardt to lend a hand.

Donations for wildfire victims were pouring in from around the state, but the firefighters seemed to be forgotten.

That's why she asked Dr. Marquardt if she could use part of her time in the office to help the firefighting effort. The doctor agreed, and she started making calls, looking for donations.

"I have always felt that individuals and independent businesses can make a difference in the lives of our friends and neighbors in need," said Dr. Marquardt, who is also a former New Mexico state representative. "Alcon Laboratories also has been a great partner in this effort, responding immediately to our call and with such a significant contribution."

Alcon Laboratories and Marquardt Eye Associates teamed up to donate an entire palette of eyedrops to the cause.

"I am so proud of how our staff saw a need, met the challenge, and delivered needed help and services to guard and protect the eye health of our firefighters," said Dr. Marquardt.

Forest officials say the fire has burned more than 200 residential structures and 10 outbuildings.

Members of the community like Dr. Marquardt and his staff said they are glad Ruidoso residents know there is someone looking out for them in their time of need.

Terry Marquardt, O.D., and staff member Chrissie Kenaston are wowed at the arrival of the palette of eyedrops from Alcon Laboratories.

Codeheads,

from page 32

Procedural Terminology (CPT© American Medical Association) definitions for the chosen codes.

I've spoken with doctors who are shocked to learn that it is their own professional judgment that should determine which questions are asked of each patient, which tests are provided for each patient, and how frequently the patient is re-examined.

The influence of well-developed protocols for the provision of care, accurate coding

My consideration of these several observations relative to the "medical model" for the provision of care has brought me to the following conclusion: the "medical model" really has not changed at all.

Patient care, doctors' records of the care provided, Medicare and insurance claims for those services, reimbursements for those services, and ultimately, the outcome of insurers' audits of the care provided are and always have been best served when providers follow several key caveats:

- All case history questions, all care provided, all diagnoses and management options recorded for every patient visit must be based on the needs of the patient that day, as expressed in the reason for the visit (chief complaint, presenting problem, doctor's order for return to the office, symptoms, etc.).
- All information related to the patient's case (history/ exam/ medical decision-making/ management options/ orders/ additional testing) must be carefully recorded in the medical record.
- Each medical record must be signed (in pen or, in EHRs, electronically) by the doctor responsible for the care and must bear the legible identity of the doctor (typed/ printed/ stamped).
- All CPT codes (office visit, surgery, procedures) are chosen by comparing the contents of the medical record with the CPT definitions for the related codes.
- All claims are submitted based on national rules (CPT and ICD-9) and on forms or electronically, complying with the rules of the patient's insurer.

Now that is a "medical model" all health care providers can live with!

AOA Trustee Andrea Thau, O.D., is shown with Tricia Elsberry, O.D., president of the Arkansas Optometric Association (ArOA), at the ArOA annual meeting this spring.

mTBI,

from page 35

minute bout, the athletes were retested and the time it took to complete the test was logged and compared with the baseline established before the match.

A longer, more comprehensive test, called the Military Acute Concussion Evaluation (MACE), was also administered as a means of comparison. Athletes who scored poorly on the K-D test also tested poorly on the MACE test. The limitation in drawing conclusions from the only study of the K-D Test for detection of concussion was that only boxers who were suspected by a physician of having brain trauma received the MACE test, which may have distorted the study results.

The authors state, "Saccadic and other types of eye movements are frequently abnormal following concussion, and early eye movement function may serve as a predictor of post-concussion syndrome."

The authors further claim in their study that the "K-D test is based on measurement of the speed of rapid number naming." "As such, the K-D test can capture impairment of eye movements, attention, language, and other areas that correlate with suboptimal brain function." "To the extent that the K-D test captures saccadic eye movements among other important elements of rapid number naming, this data suggest that this quick screening test will be helpful in identifying athletes with signs of concussion."

Ongoing controversy

However, a previous study, published almost 30 years prior in *Optometry: Journal of the American Optometric Association*, found that eye movement skills measured with subjective visual-verbal formats, such as used in the K-D Test, are deficits in automaticity of number knowledge ability and not oculomotor dysfunctions. That suggests the decreases in K-D test time, reported in the *Neurology* study, cannot clearly be attributed to impaired eye movements, delayed number naming, or any other cause.

The K-D Test fails to control for a significant flaw, specifically the impact of inadequate automatic recall of numbers and the verbal component of calling out numbers. Delayed and slurred speech is a recognized symptom of concussions.

If speech processing is impaired, it may directly affect the speed of rapid naming of numbers and not oculomotor performance. Moreover, there is a test, the Developmental Eye Movement test, which does differentiate the role of rapid number naming and oculomotor function. This test has been widely used for over three decades for clinical testing. Unfortunately, this lack of differentiation in increased time in the K-D test was not addressed and poses several significant questions about the adequacy of the K-D Test in screening for concussion. Understandably, the prospect of inexpensive, objective, sideline concussion screening tools has been greeted with enthusiasm in the media and the world of sports over the past couple of years.

However, more recently, many have been more tempered in their response and, as reported by CNN, various experts in the concussion field have stressed the importance of additional research such as replicating the *Neurology* findings with a larger study group and among participants in different sports.

"This test seems applicable to events where you can do a baseline right before the game," said Jeffrey Kutcher, M.D., a concussion expert and director of the Michigan NeuroSport Program. "That's not always a feasible thing to do, so more study has to be done to look at whether this tool will be valuable in situations where you do preseason baselines. Given the variables, it's possible it won't be as valuable in that situation."

Indiana University (IU) optometry students gear up for the Varilux Optometry Student Bowl at Optometry's Meeting™ last month. IU's Karen Lee came out on top in the competition. In addition to bragging rights, IU took home $1,000 and the coveted crystal trophy.

The *Neurology* study has other limitations, according to Dr. Kutcher: its small size; the athletes sparred for a relative short period of time. Dr. Kutcher, who is also chair of the Sports Neurology Section of the American Academy of Neurology, said he would like to see how well K-D works in sports with longer durations such as soccer or hockey, where fatigue might influence test results. What also remains to be seen is whether test results pan out the same way among athletes in other sports, many of which involve subtler blows and different mechanisms for causing concussion from the ones that might occur during a mixed martial arts or boxing match.

"Not all concussions are created equal," said Steven Galetta, M.D., a co-author of the *Neurology* study. "We are studying other cohorts of athletes who may not suffer overt head trauma or where there are different mechanisms of concussion. We do need to validate this in other populations of athletes. Indeed, another study was performed and revealed changes in the scores following concussion, yet the authors acknowledge need for follow-up to further examine the effectiveness of the K-D test.

Despite the study's limitations, Dr. Kutcher calls the K-D test "an interesting and a novel approach" and said he plans to try it out on athletes in his own practice.

Addressing mTBI in practice

Given the difficulties in testing for concussion, it is important to manage concussions on an individualized basis and to implement baseline testing and/or post-injury neurocognitive testing. This type of concussion assessment can help to objectively evaluate the concussed athlete's post-injury condition and track recovery for safe return-to-play, thus preventing the cumulative effects of concussion. In fact, neurocognitive testing has recently been called the "cornerstone" of proper concussion management by an international panel of sports medicine experts.

Sports-related concussions can result in varied signs and symptoms. The need for rapid on-the-field screening and testing for concussions is apparent. The clinician should be aware of limitations related to the use of brief concussion screening tools and have a complete grasp of guidelines for the administration, scoring, and interpretation of a screening instrument before applying it in a clinical testing site. The danger of any screening test is a significant number of false negatives, where the athlete is "passed" and actually did have a concussion with no follow up as a result of passing the test. Caution should be exercised in using a rapid screening test (e.g., the K-D test) which has not fully established its accuracy in identifying those athletes with and without mild traumatic brain injuries.

Perhaps as more studies are done and what it is actually measuring is clarified, the value of screening tests that employ rapid naming and eye movement speed may be more evident. A considerable amount of additional research on rapid concussion screening is reportedly under way.

Nevertheless, practicing optometrists must be preparing to meet the growing demand for mTBI-related care now. Practitioners should keep up-to-date with the latest research, have ready advice for patients or the general public on the ocular aspects of brain trauma, and, above all, be prepared to provide the best available care for patients with such injury.

Today, mTBI is a subject no practicing optometrist can ignore.

Survey finds almost 70% with dry eye don't see ECP

By Marc R. Bloomenstein, O.D.

The results of an online survey conducted by Harris Interactive on Consumer Attitudes Related to Dry Eye should be an eye opener to optometrists who see asymptomatic healthy adults. This study, sponsored by Allergan, Inc., exposed the fact that patients have a lot more to say about their dry eye than eye care practitioners may realize.

Although, practitioners have known for years that the prevalence of dry eye symptoms is highest in females and increases with age, the study indicates that males are also susceptible. Moreover, some individuals, male and female, have been experiencing symptoms for more than 10 years. Sadly, this means that practitioners have been status-quo in their treatment regimen for a chronic medical condition that causes almost 42 percent of female patients to state that it blurs their vision and 43 percent to state that it made reading more challenging.

The most obvious message this survey highlights is that practitioners are not doing enough to help patients who have dry eye. Almost 50 percent of all adults are experiencing dry eye symptoms daily, and an equal number of respondents are using over-the-counter (OTC) eyedrops to manage these symptoms without success. The implication is that eye care professionals feel they are managing their patients effectively with a recommendation of OTC eyedrops. Fortunately, 50 percent of the respondents said their decision to use OTC drops was a consequence of their visit with the eye care professional. On the surface this may seem like a positive, yet when 63 percent of those same patients, using drops, decry that OTC drops are only somewhat or not at all successful in managing their dry eye symptoms, practitioners really should be asking themselves if they are influencing patients in the most efficacious manner.

The use of OTC tears is the first line defense for a chronic condition that can affect the quality of our patients' lives. However, practitioners generally realize most patients are already using an OTC drop to alleviate symptoms when they come in for an appointment. Moreover, most are using drops that may be exacerbating the dryness by also inducing a whitening effect.

Optometrists need to present solutions to our patients at every opportunity. As approximately 70 percent of all U.S. adults who experience one or more dry eye symptom(s) are not seeking our services, the onus to provide a treatment for dry eye should be a priority at every visit.

A vast majority of patients seek eye care services because the have already made some assumptions as to what is ailing their vision. Because these same patients are also using OTC eyedrops to attempt relief, eye care practitioners should look to provide better solutions. This author's treatment regimen is to pick up where patients have already started. A practitioner should not be willing to substitute one OTC product for another. Ensuring that patients do not have concomitant factors that are contributing to the dry eye, such as blepharitis, can enable a reduction in symptoms. The use of punctal plugs, introducing steroids, or prescribing Cyclosporine A may also be necessary, and these can only be provided by the practitioner.

This survey is effectively a memorandum from patients stating that eye care practitioners need to stop being so myopic when it comes to treating dry eye. Patients need and demand better treatment regimens.

Consumer attitudes about dry eye

- Nearly half of all U.S. adults (48 percent) experience one or more dry eye symptom regularly
- Half of all women (52 percent) experience one or more dry eye symptom regularly; 43 percent of men experience one or more dry eye symptom regularly
- Nearly one in five U.S. adults (19 percent) report using OTC eyedrops to treat symptoms at least five times per week
- A majority of U.S. adults who use OTC eyedrops to manage their dry eye symptoms (63 percent) said the OTC drops are only somewhat or not at all successful in managing their dry eye symptoms
- Sixty-nine percent of U.S. adults who experience one or more dry eye symptom have not visited an eye care professional to treat symptoms
- Approximately two in five (41 percent) who visited an eye care professional to treat their dry eye symptoms said they visited more than once before finding relief (19 percent) or that they still have not found relief (22 percent)

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Industry Profile is a regular feature in AOA News allowing participants of the Ophthalmic Council ™ to express themselves on issues and products they consider important to the members of the AOA.

Vistakon study shows discrepancies between attitudes, practices

While Americans rank sight as the most important of the five senses, a new survey shows that nearly half did not get an eye exam in the past year and approximately 30 percent do not believe that taking care of their eyes is as important as other health issues. The 2012 Americans' Attitudes and Perceptions About Vision Care Survey, conducted online by Harris Interactive© on behalf of Vistakon® Division Johnson & Johnson Vision Care, Inc., tracked attitude and behavior changes among 1,000 U.S. adults compared to 2006 benchmark data and revealed surprising discrepancies between attitudes about vision care and actual practices.

Results show a consistently high value placed on maintaining proper vision, although the number of respondents who indicated they do not regularly visit an eye care professional increased 36 percent compared to 2006 (19 percent vs. 14 percent in 2006). Alarmingly, approximately one in five (21 percent) U.S. adults mistakenly agrees that they do not need an eye exam unless they are having trouble seeing.

"Despite knowledge and perceived importance, Americans are not making eye health a medical priority," said Cristina Schnider, O.D., senior director, Professional Communications, Vistakon®. "Seeing an eye care professional regularly for a comprehensive eye exam will not only assess vision and the potential need for updated prescriptions, but it may also help identify and lead to a diagnosis of other health concerns such as hypertension and diabetes."

Among the respondents who have a regular eye care professional, the study shows an upward trend in satisfaction rates. Significantly more U.S. adults are extremely/very satisfied with their regular eye care professional, an 18 percent increase vs. 2006 (80 percent vs. 68 percent in 2006). When asked about the reason for their last eye exam, significantly more respondents noted that they had established a set eye exam schedule (32 percent vs. 29 percent in 2006) or received a reminder from the eye doctor's office (20 percent vs. 17 percent in 2006) (an increase of 10 and 18 percent, respectively).

Nearly 80 percent of respondents indicated they sought a referral when selecting their current eye care professional, with a family member, friend or co-worker serving as the single greatest referral source (40 percent), followed by a health care provider (21 percent). Women were significantly more likely than men to seek referrals for a new eye care professional (48 percent vs. 37 percent, respectively).

Sources for obtaining information on vision care products are also evolving. Eye care provider's offices remain the No. 1 resource – and the most trusted/reliable – but a growing number of U.S. adults say they seek out a family member or friend for information. The Internet has also gained traction; an increase of 33 percent of respondents cited this as an information resource for vision care (20 percent vs. 5 percent in 2006).

Other findings from the survey included:

- Many attitudes regarding contact lenses did not change significantly since 2006, with the exception that significantly more contact lens wearers agree that it is important to take lenses out daily to give their eyes a rest (93 percent, 2012 vs. 86 percent, 2006), and about one-in-five contact lens wearers (17 percent) say they wear daily-disposable contact lenses.
- Cost is less of a barrier to vision care: Approximately three in 10 adults (29 percent) agree that they avoid going to their eye doctor because of cost, a 12 percent decrease vs. 2006 and two in three adults have some type of eye care insurance coverage.
- Vision correction surgery remains minimal: 6 percent of U.S. adults reported having vision correction surgery, compared to seven percent in 2006, and the likelihood to have vision correction surgery is significantly less, declining from 10 percent extremely/very likely in 2006 to six percent in 2012.

For an executive summary of the survey, email *visioninamerica@its.jnj.com*.

B+L applies for FDA Prolensa drug approval

Bausch + Lomb, the global eye health company, announced it has submitted a New Drug Application (NDA) to the U.S. Food and Drug Administration (FDA) seeking approval for Prolensa™ (bromfenac ophthalmic solution), a once-daily topical nonsteroidal anti-inflammatory compound for the treatment of ocular inflammation and pain following cataract surgery.

Prolensa, developed by recently acquired ISTA Pharmaceuticals, Inc., incorporates a lower concentration of bromfenac than the currently available once-daily Bromday™ (bromfenac ophthalmic solution) 0.09%, in a new formulation.

"The new, optimized formulation used for Prolensa allows for a lower concentration of bromfenac, while maintaining the convenience of once-daily use currently prescribed with Bromday," said Calvin Roberts, M.D., executive vice president, chief medical officer, Bausch + Lomb.

A patent for Prolensa's formulation and method of use, expiring in 2025, was recently issued to the licensor, Senju Pharmaceutical Co. Ltd., by the United States Patent and Trademark Office.

"The Prolensa filing is an important step toward bringing safe, effective and meaningful medical advances to medical professionals and their patients," said Marvin Garrett, vice president of U.S. Regulatory Affairs, Quality Assurance and Compliance, Bausch + Lomb. "It's also a timely example of the progress we continue to make on critical D&R programs as we work to bring together the best of ISTA Pharmaceuticals and Bausch + Lomb."

Clariti Eyewear introduces its new collection of Airmag frames. Airmags feature a magnetic polarized lens clip-on. Shown is A6016 in burgundy. *www.claritieyewear.com*

Safilo Group features the Carrera 6000 collection, a timeless and iconic square sunglass shape, offered in 12 colors in the U.S. market. It's shown in Azure SS Flare. www.safilousa.com

Transitions encourages ECPs to 'get digital' with new social media and digital marketing guide

The rapid growth of social media and mobile device use in America and across the globe is creating more opportunities for consumers to search for and connect with family, friends, coworkers and businesses at any place or time of the day.

Recognizing this, Transitions Optical, Inc. introduced a new guide book, "Getting Digital: Social Media and Digital Marketing For Your Practice," to help eye care professionals better understand the different social networking sites and online digital tools available to them and identify which resources can add value to their marketing and patient outreach efforts.

Transitions Optical first began its trade social media initiative in 2009, with the launch of the Transitions Lenses: Healthy Sight Professionals Facebook page and "Putting Your Practice on Facebook," a beginners guide to social media.

In 2010, Transitions Optical introduced a second guide, "Getting Social: Social Media For Your Practice," providing the industry with a more in-depth look at the most popular forms of social media.

Now available, the new Getting Digital guide features updated and expanded content, giving eye care professionals an overview of how social tools – including Facebook, Twitter, LinkedIn, YouTube, Yelp and Foursquare – work and ideas for leveraging them to connect with patients.

The guide also includes a section on digital tools – such as online daily deal sites, like Groupon or Signpost, Quick Response (QR) codes, and email or text message reminder services – offering eyecare practices new tactics for encouraging patients to think about their eye health and scheduling their next appointment.

"There are social media and digital tools out there for every practice – no matter what your budget or experience – and they can complement marketing and communication efforts already in place," said Dana Reid, marketing manager, ECP communications, Transitions Optical. "Deciding which areas to focus on does take time, but it's an investment that can really pay off. Ensuring that you are easily searchable and engaging patients who are on their smartphones or tablet devices is becoming more important."

The guide also includes sections on how to get started, suggestions for keeping up with new trends, best practices to follow and mistakes to avoid. Getting Digital is available for download through the marketing tools section of Transitions Optical's trade portal at *www.Transitions.com/Pro*.

VisionWeb awards record-setting royalty payments to AOA state affiliates

VisionWeb announced it will pay $60,882 in royalties to participating AOA state affiliates. The royalties are for eye care product orders placed by their members on VisionWeb over the last 12 months.

This is the ninth year VisionWeb has paid royalties to the AOA for orders placed by its members to the VisionWeb supplier network of more than 400 suppliers in the United States. Since initiating the program in 2004, VisionWeb has paid a total of $319,667 in AOA royalties to participating state affiliates.

Further detail on VisionWeb's AOA Royalty Program are available at *www.visionweb.com/vwcontent/order_products/vision-web-royalty-programs.html*.

More than 1,000 accounts qualified to earn royalties this year, a 10 percent increase over last year. This participation growth is reflected n the royalty payout that increased by 12 percent over the previous earning period, making this the largest royalty payment in the program's history.

"Eye care practices in the U.S. are relying on the efficiencies associated with VisionWeb's online ordering services now more than ever, and that is especially evident in this year's record-setting royalty earning" said Ken Engelhart, president and chief executive officer of VisionWeb. "We are thrilled to reward independent optometrists for adopting innovative technology and incorporating efficient processes in their practices through our AOA Royalty Program. It is exciting to see how the program has grown over the past nine years and we look forward to its continued success."

"We are thrilled to reward independent optometrists for adopting innovative technology and incorporating efficient processes in their practices through our AOA Royalty Program."

The royalty program enables AOA members to automatically earn royalties for their state affiliates when they use VisionWeb to place their eye care product orders. To do so, members need to place a minimum of 1,200 orders through VisionWeb annually. Once this minimum threshold is reached, members are qualified to earn royalties. Each order placed through VisionWeb is associated with a transaction fee – the fee paid to VisionWeb by the supplier who receives the order – and the incremental royalty is calculated as a percentage of each fee.

Royalties brought in by all qualifying accounts are combined by state to determine the royalties earned by each participating AOA state affiliate. Participating AOA state affiliates receive royalties from VisionWeb, exclusive of any agreement they may have with buying groups. Ordering on VisionWeb does not interfere with buying group discounts or pricing relationships.

AOA members interested in this program can contact their affiliate to find out more. For further information on the program, visit *www.visionweb.com* or call 800-874-6601.

MEETINGS

July

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
CE IN THE ROCKIES
July 26-29, 2012
Rocky Mountain Park Inn
Estes Park, CO
713-743-1900
http://ce.opt.uh.edu/live-events/Rockies2012

FOUNDATION OF VISION THERAPY, PART 11
July 27-29, 2012
Franklin, TN
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

SACRAMENTO VALLEY OPTOMETRY SOCIETY
TAHOE SEMINAR
July 27-29, 2012
North Lake Tahoe
Hyatt Regency Hotel
Incline Village, NV
jerrysue@svos.info
www.svos.info

ALABAMA OPTOMETRIC ASSOCIATION
GULF COAST SUMMER CONFERENCE
July 27-28, 2012
The Grand Hotel Marriott Resort
Point Clear, Alabama
334-273-7895
www.alaopt.org

August

SOUTHWEST FLORIDA OPTOMETRIC ASSOCIATION
EDUCATIONAL RETREAT 2012
August 3-5, 2012
South Seas Island Resort
Sanibel Island, FL
Brad Middaugh, O.D.
239/481-7799
swfoa@att.net
www.swfoa.com

WISCONSIN OPTOMETRIC ASSOCIATION
SUMMER EDUCATION EVENT
August 3-4, 2012
Blue Harbor Resort, Sheboygan, WI
800/678-5357
joleenwoaoffice@tds.net
www.woa-eyes.org

KEY WEST EDUCATIONAL CONFERENCE THE FOUNDATION FOR OCULAR HEALTH
August 10, 2012
Key West, Florida
Gloria Ayan
gayan@araneye.com
305/491-3747

NOVA SOUTHEASTERN UNIVERSITY
SUPER SUNDAY #1
August 19, 2012
Orlando, FL
954/262-4224
oceaa@nova.edu
optometry.nova.edu/ce/index.html

IDAHO OPTOMETRIC PHYSICIANS ANNUAL CONGRESS
Featuring Drs. Paul Karpecki, Charles Brownlow & Nathan Lighthizer
August 23-25, 2012
The Grove Hotel
Boise, ID
Randy L. Andregg, O.D.
208/461-0001
randregg@vision-1.com

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
105TH SCOPA ANNUAL MEETING
August 23-26, 2012
Myrtle Beach Marriott Resort & Spa at Grande Dunes
Myrtle Beach, SC
Jackie Rivers/Anna Straub
877/799-6721
info@sceyedoctors.com
www.sceyedoctors.com

September

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
ONLINE TEXAS OPTOMETRIC GLAUCOMA CERTIFICATION COURSE
September 5-October 19, 2012
UH College of Optometry
Houston, TX
713/743-1900

MIDDLE ATLANTIC OPTOMETRIC CONGRESS
September 6-9, 2012
Doubletree Hotel and Convention Center, Monroeville, PA
Barry Cohen, O.D.
barryc51@gmail.com

OEP CLINICAL CURRICULUM
THE ART & SCIENCE OF OPTOMETRIC CARE-A BEHAVIORAL PERSPECTIVE
September 6-10, 2012
Grand Rapids, MI
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

OPTOMETRIC EXTENSION PROGRAM FOUNDATION
43RD ANNUAL COLORADO VISION TRAINING CONFERENCE
September 7-9, 2012
YMCA of the Rockies
Estes Park, CO
303/683-4466
drjamieanderson@gmail.com
www.visioncare.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH SALUS UNIVERSITY
September 7-9, 2012
Elkins Park, PA
402/680-4634
http://salus.edu/alumni/alumni_ce.html

NOVA SOUTHEASTERN UNIVERSITY
FALL CONFERENCE
September 8-9, 2012
Fort Lauderdale, FL
954/262-4224
oceaa@nova.edu
http://optometry.nova.edu/ce/index.html

NORTHEASTERN STATE UNIVERSITY, OKLAHOMA COLLEGE OF OPTOMETRY
FALL PRIMARY EYE CARE UPDATE
September 8-9, 2012
Northeastern State University, Oklahoma College of Optometry, Tahlequah, OK
918/444-4033
Beason01@nsuok.edu
http://optometry.nsuok.edu/ContinuingEducation.aspx

NORTHEAST CONGRESS
September 9-10, 2012
Westford, MA
Kathleen Prucnal, O.D.
978/597-5227
drkaprucnal@msn.com

ENVISION CONFERENCE 2012
September 12-15, 2012
Hilton St. Louis at the Ballpark
St. Louis, MO
info@envisionconference.org
www.envisionconference.org

SOUTH DAKOTA OPTOMETRIC SOCIETY
FALL CONFERENCE
September 13-14, 2012
Hilton Garden Inn, Sioux Falls, SD
Deb Mortenson, Exec. Dir.
605/224-8199
Deb.mortenson@pie.midco.net
www.sdeyes.org

CE IN ITALY
September 14-16, 2012
Florence, Italy
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

SOUTHWEST COUNCIL OF OPTOMETRY
SWCO MEETING
September 14-16, 2012
InterContinental Hotel, Addison, TX
Niki Bedell, M.P.H.
713/743-1856
FAX: 713/743-6541
www.swco.org

VERMONT OPTOMETRIC ASSOCIATION
ANNUAL MEETING
September 14-16, 2012
Basin Harbor Club, Vergennes, VT
David J. DiMarco, O.D.
802/524-9561
FAX: 802/524-6060
djd@nveyecare.net

CE IN ITALY
September 18-20, 2012
Tuscany Immersion: Castiglion Fiorentino
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

NEBRASKA OPTOMETRIC ASSOCIATION
FALL CONFERENCE
September 21-23, 2012
Younes Conference Center
Kearney, NE
noa@AssocOffice.net
Nebraska.aoa.org

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
CE IN FORT WORTH
September 22-23, 2012
Alcon Laboratories Schollmaier Auditorium
Fort Worth, TX
713/743-1900
Http://ce.opt.uh.edu/live-events/ceinftw2012

AEA CRUISES OPTOMETRIC SEMINAR
CANADA-NEW ENGLAND
September 22-29, 2012
Aboard the Caribbean Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com

CENTRAL PENNSYLVANIA OPTOMETRIC SOCIETY CE FORUM XVI
Featuring Melton and Thomas
September 23, 2012
The Hotel Hershey
Hershey, PA
Mary Good, O.D.
cposrsvp@gmail.com

AEA CRUISES OPTOMETRIC SEMINAR
VENETIAN INTERLUDE
September 23-30, 2012
Aboard the Ocean Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com

WISCONSIN OPTOMETRIC ASSOCIATION
CONVENTION AND ANNUAL MEETING
September 27-30, 2012
Kalahari Resort, Wisconsin Dells, WI
800/678-5357
joleenwoaoffice@tds.net
www.woa-eyes.org

ILLINOIS OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
September 28-30, 2012
Crowne Plaza Hotel, Springfield, IL
800/933-7289
www.ioaweb.org

FALL CONFERENCE
KENTUCKY OPTOMETRIC ASSOCIATION
September 28-30, 2012
Embassy Suites Hotel
Lexington, KY
sarah@kyeyes.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH THE TEXAS OPTOMETRIC ASSOCIATION AND UNIVERSITY OF HOUSTON
September 29-30, 2012
University of Houston Campus
Houston, TX
402/680-4634
http://www.ce.opt.uh.edu/live-events/OptoBCertification

NORTH DAKOTA OPTOMETRIC ASSOCIATION
109TH ANNUAL CONGRESS & EXHIBITION
September 30 - October 2, 2012
Ramkota Hotel, Bismarck, ND
701/258-6766
Toll Free 877/637-2026
FAX: 701/258-9005
ndoa@btinet.net
www.ndeyecare.com

October

OHIO OPTOMETRIC ASSOCIATION
EASTWEST EYE CONFERENCE
October 4-7, 2012
Public Auditorium, Cleveland, OH
Linda Fette
800/999-4939
linda@ooa.org
www.eastwesteye.org

SOUTHERN COLLEGE OF OPTOMETRY'S 2012 FALL CONTINUING EDUCATION AND HOMECOMING WEEKEND
October 4-7, 2012
SCO Campus and The Peabody Memphis Hotel, Memphis, TN
Carla O'Brian, 800-238-0180, ext. 5
901/722-3235
ce@sco.edu
www.sco.edu

PSS EYECARE
PSS 2012: FORUM ON OCULAR DISEASE
October 6-7, 2012
The Castle Hotel, Orlando, FL
education@psseyecare.com
www.psseyecare.com

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
WEST TEXAS TWO STEP
October 6-7, 2012
Embassy Suites Hotel
Lubbock, TX
713/743-1900
http://ce.opt.uh.edu/live-events/wtx2012

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
CE IN HOUSTON
October 7, 2012
University of Houston College of Optometry Room
Houston, TX
713/743-1900
http://ce.opt.uh.edu/live-events/ceinhouston2012

Michigan Optometric Association
44th Annual Fall Seminar
October 10-11, 2012
Lansing Center, Lansing, MI
Amy Possavino
517/482-0616
FAX: 517/482-1611
amy@themoa.org
www.themoa.org

WISCONSIN OPTOMETRIC ASSOCIATION
NORTHWOODS EDUCATION EVENTS
October 12-13, 2012
Black Bear Lodge, St. Germain, WI
800/678-5357
joleenwoaoffice@tds.net
www.woa-eyes.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH THE COLORADO OPTOMETRIC ASSOCIATION
October 12-13, 2012
402/680-4634
http://www.visioncare.org/_programs_information/events.php

HUDSON VALLEY OPTOMETRIC SOCIETY FALL SEMINAR
October 12, 2012
The Grandview
Poughkeepsie, NY
Robert Greenbaum, O.D.
845/473-0220
Robertgreenbaum58@gmail.com
www.hvos.org

VIRGINIA OPTOMETRIC ASSOCIATION
FALL CONFERENCE
October 13-14, 2012
Lansdowne Resort
Leesburg, VA
Bruce Keeney
804/643-0309
www.thevoa.org

IOWA OPTOMETRIC ASSOCIATION
IOWA HAWKEYE INSTITUTE
October 18-19, 2012
Cedar Rapids Marriott
Cedar Rapids, IA
319/393-6600
800/396-2153
www.marriott.com/hotels/travel/cidmc-cedar-rapids-marriott/
or www.marriott.com

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH THE NEW HAMPSHIRE OPTOMETRIC ASSOCIATION
October 19-21, 2012
402/680-4634
http://www.nheyedoctors.biz/2012_weekend.htm

November

OEP CLINICAL CURRICULUM
VT/STRABISMUS & AMBLYOPIA
November 1-4, 2012
Western University College of Optometry, Pomona, CA
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

ALABAMA OPTOMETRIC ASSOCIATION
2012 ALOA ANNUAL CONVENTION
November 2-4, 2012
The Wynfrey Hotel
Birmingham, AL
334/273-7895
www.alaopt.com

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
CE IN AUSTIN
November 3-4, 2012
Omni Austin Hotel Downtown
Austin, TX
713/743-1900
http://ce.opt.uh.edu/live-events/ceinaustin2012

CALIFORNIA OPTOMETRIC ASSOCIATION
MONTEREY SYMPOSIUM
November 9-10, 2012
Monterey Marriott Hotel & Conf. Center
Will Curtis
916/266-5037
wcurtis@coavision.org

PACIFIC UNIVERSITY, COLLEGE OF OPTOMETRY CE CHARLESTON
November 9-10, 2012
Doubletree Suites, Charleston, SC
Jeanne Oliver
503/352-2740
FAX: 503/352-2929
Jeanne@pacificu.edu
www.pacificu.edu/optometry/ce

FELLOWSHIP OF CHRISTIAN OPTOMETRISTS, INTERNATIONAL
23RD ANNUAL EDUCATIONAL CONFERENCE
November 9-11, 2012
Abe Martin Lodge, Brown County State Park
Nashville, IN
850/530-9626
foreknown@aol.com
www.fcoint.org/services/annualConference.html

WISCONSIN OPTOMETRIC ASSOCIATION
PRIMARY CARE SYMPOSIUM
November 9-10, 2012
Country Springs Hotel, Waukesha, WI
800/678-5357
joleenwoaoffice@tds.net
www.woa-eyes.org

NOVA SOUTHEASTERN UNIVERSITY
SUPER SUNDAY #2
November 11, 2012
Orlando, FL
954/262-4224
oceaa@nova.edu
http://optometry.nova.edu/ce/index.html

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
EVERYTHING THERAPEUTIC
November 17-18, 2012
The Westin Riverwalk Navarro Ballroom
San Antonio, TX
713/743-1900
Http://ce.opt.uh.edu/live-events/everythingtherapeutic2012

OEP CLINICAL CURRICULUM
VT/VISUAL DYSFUNCTIONS
November 29-December 3, 2012
Grand Rapids, MI
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

For featured calendar events, email t.peppers@elsevier.com.

To submit standard items for the meetings calendar, send a note to eventcalendar@aoa.org.

Please allow several months' lead time.

Sept. 12-15, 2012
Hilton St. Louis at the Ballpark
St. Louis, MO

info@envisionconference.org
www.envisionconference.org

December

UNIVERSITY OF HOUSTON
COLLEGE OF OPTOMETRY
29TH ANNUAL CORNEA, CONTACT LENS & CONTEMPORARY VISION CARE SYMPOSIUM
December 1-2, 2012
The Westin Memorial City
Houston, TX
713/743-1900
http://ce.opt.uh.edu/live-events/ccls2012

February

SKIVISION 2013
February 16-20, 2013
Snowmass Village, CO
888/SKI-2530
Questions@SkiVision.com
www.SkiVision.com

SECO INTERNATIONAL 2013
February 27-March 3, 2013
Georgia World Congress Center, Building A, Atlanta, GA
Bonny Fripp
770/451-8206, ext. 13
FAX: 770/451-3156
bfripp@secostaff.com

AOA Vision Rehabilitation Section AMD A to Z 2012 course schedule

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
105TH SCOPA ANNUAL MEETING
MYRTLE BEACH, S.C.
SPEAKERS: DAWN DECARLO, O.D.
JUSTIN GREEN, PH.D.
AUG. 24-25, 2012
DAY/TIME TBD

NEW JERSEY SOCIETY OF OPTOMETRIC PHYSICIANS
THERAPY BY THE SEA
SHERATON ATLANTIC CITY HOTEL AND CONVENTION CENTER, ATLANTIC CITY, N.J.
SPEAKERS: DAVID LEWERENZ, O.D.
JUSTIN GREEN, PH.D.
SEPT. 22, 2012
10 a.m.– noon

For additional information contact Melissa Flower-*MLFlower@aoa.org*. The schedule and presenters are subject to change.

SHOWCASE YOUR BRAND

Friends & Family Referrals, Visually Simple

Your Choice of 4 Customized Designs

American Optometric Association

To Promote "Word of Mouth" Practice Growth

24"x 30" Ready to Display Canvas Artwork Kits

FF-1

FF-2

FF-3

Distribute More Referral Cards with Less Time

Each Branded Practice Growth Kit Features:

- 1 Large Format Canvas with your logo
- 1000 Friends & Family Referral Cards with your logo & location information
- 1 Referral Card Holder for canvas display
- 1 Display Easel takes less than 3 sq. ft. of floor space
- **Member Price, only $299** *plus shipping*

front & back

Referral Cards
(included with each kit)

Thank You Cards (sold separately)

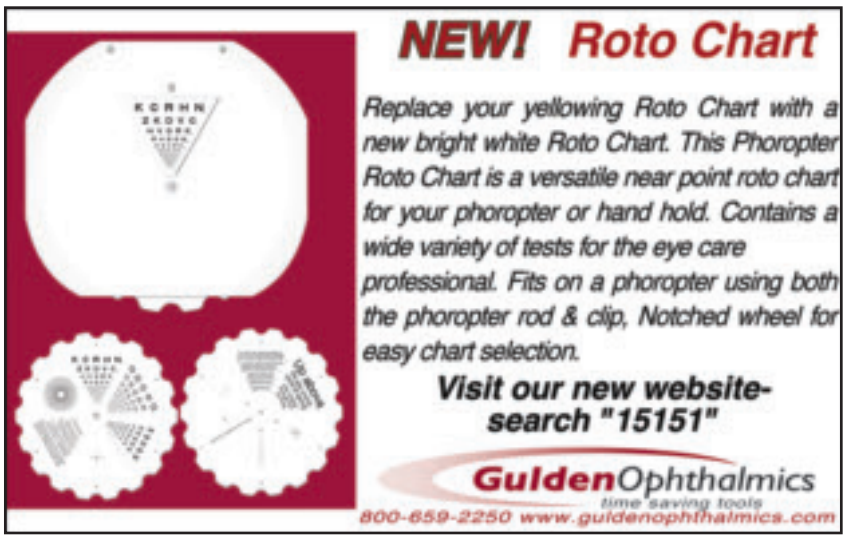
front & back (blank inside)

Promoting Your Friends & Family Referrals is as easy as 1-2-3

1. *Display your customized canvas in a highly visible location*
2. *Keep your referral card holder fully stocked*
3. *Mail a Thank You card with more Friends & Family referral cards for each new patient response*

Start Building Your Practice Growth Collection Today!

Call the AOA Marketplace at 800-262-2210, visit www.aoapracticegrowth.com or scan this QR Code with your mobile phone.



NORTHEASTERN
STATE UNIVERSITY

www.optometry.nsuok.edu

THE OKLAHOMA COLLEGE OF OPTOMETRY

is accepting applications for two full-time faculty positions. Experience in full-scope Primary Care is required. One position is tenure eligible and will include classroom and clinical teaching duties. The second position is a non-tenure track position with responsibilities for providing direct clinical care and clinical teaching. Applicants' qualifications must include the O.D. degree and eligibility for licensure in **Oklahoma**. Preference will be given to applicants with advanced academic degrees, residency training, extensive clinical experience, or teaching experience. The positions will be open until filled.

To apply for a faculty position using our online application system, please use the following URL: https://nsuok.peopleadmin.com/

Three letters of reference should also be sent to:
Michelle Welch, O.D.
1001 N. Grand Ave
Tahlequah, OK 74464
welchr@nsuok.edu

Ref: Position # EOOO2015 and #PPCN2001

Questions concerning the positions may be directed to Dr. Welch.

NSU is an Affirmative Action/Equal Opportunity Employer.

VICE PRESIDENT OF ACADEMIC AFFAIRS, APPALACHIAN COLLEGE OF OPTOMETRY

The Appalachian College of Optometry seeks applications from qualified candidates to serve as the Vice President of Academic affairs for its new College of Optometry. Located in Grundy, Virginia, the College will join an already fully accredited College of Law (www.asl.edu) and College of Pharmacy (www.acpharm.org) as the third professional College funded by the Buchanan County Industrial Development Authority.

The Vice President must be a proven leader who can provide the needed dynamic and effective leadership required to implement the Appalachian College of Optometry. The vice president will be responsibilities will include contributions to developing curriculum, recruiting faculty, contributing to completion of self study, development of faculty and student handbooks, preparation for accreditation requirements for the ACOE and SACS, regional accreditation body and any other project as directed by the president towards the development and advancement of the college.

The vice president must have an earned Doctor of Optometry (OD) degree; hold a current license to practice optometry; be qualified for optometry licensure in the State of Virginia; demonstrate excellent oral, written, and interpersonal communication skills; have demonstrated a history of excellent organizational, priority management, and teamwork skills; be a proven leader in optometry and/or have had at least two years of successful experience in a leadership position in another ACOE accredited school or college of optometry.

Interested candidates should electronically submit a letter of intent to apply for the position along with a current Curriculum Vitae to Brian Looney, O.D., F.A.A.O. at blooney2253@gmail.com

Letters of intent and Curriculum Vitaes submitted for vice president for academic affairs will be accepted until August 1,2012 and reviewed until the position is filled.

The Appalachian College of Optometry is an Equal Opportunity Employer and reserves the right to reject any and all applicants if it appears to be in the best interest of the College.

SAVE THE DATE FOR THE 11TH ANNUAL NEW YORK ENVISION

DATE: OCTOBER 20-22, 2012
LOCATION: SUNY OPTOMETRY

- Featuring Drs. Melton & Thomas on Saturday!
- All courses & Exhibit Hall back on campus at SUNY
- CEE & Medical Errors course for Florida
- Multiple Conference Packages Available
- Ocular Surface Society of Optometry Symposiumon Monday!
- Broad Array of Speakers and Topics

Full Conference Brochure to Follow

In an effort to make the CE office here at SUNY Optometry as Green and Eco Friendly as possible, we will begin sending out our CE certificates and upcoming course information via email. Please make sure we have your most up-to-date email address, as this will become our new way of disseminating all CE information and CE Certificates.

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CLASSIFIEDS

Professional Opportunities

Clinic Director- Sioux Falls, SD FT Optometrist wanted for busy progressive referral based Ophthalmology practice. No primary care or contact lenses. Residency-trained or experience in Ophthalmology practice preferred. Please forward CV/references to: Ben Jones, Administrator at ben.jones@joneseye.com

Gulf Coast Optometry is currently Seeking Full-Time optometrists with diverse practice background to practice in the following locations in Florida: Wesley Chapel, Naples, Cape Coral, Orlando, Daytona Beach, Jacksonville and Ocala. Amazing doctors technicians for support and great staff! Interested candidates should contact Katie DeLeuce @ 239-980-2806

Oldest Eye Practice in Minnesota. The latest technology and equipment. Specialization in eye diseases and Glaucoma. Please send resume to: **dkennedy6648@comcast.net**

Optometrist Wanted- Fort Myers, FL Full and Part-Time Florida licensed Optometrist wanted for a growing 2 location practice next to Lens Crafters. Full scope optometry, with large volume medical optometric care. Cataract, Lasik, Oculoplastics, and Glaucoma post-op care. Large contact lens volume practice. Latest technology including OCT, Retinal Camera, etc. Permanent position available 06/01/2012. Excellent compensation + bonus. If interested forward CV to carlossanchezod@embarqmail.com or call Dr. Sanchez @ 239-560-1571.

Optometrist Wanted- York, PA Full or part-time Fill-in Optometrist wanted for a 3 location private practice. Part-time permanent position potential. Full scope optometry with the latest technology including EHR. Fill-in position available 9/17/2012 through 12/30/2012. If interested, please forward CV to tracey@weavereye.com or call Tracey at (717)741-4788 ext. 1128. For more information on our practice visit www.weavereye.com.

The University of Alabama at Birmingham School of Optometry is seeking applications and nominations for the position of Chair for the Department of Optometry & Director of the Professional Program. Candidates should have a doctorate in optometry, be licensed to practice and be eligible for appointment at the rank of tenured Professor. Candidates should have a record of leadership and administrative ability, including experience in personnel management, budgeting, didactic and clinical teaching, curriculum design, assessment of teaching quality, and clinical research. If you would like information about this position or would like to nominate a colleague, contact Martha Bermingham, Managing Partner at Quick Leonard Kieffer at Martha@qlksearch.com or Socorro Martinez, Principal, at Smartinez@qlksearch.com. Both can be reached at 312-876-9800.

Miscellaneous

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Montana Independent Optical Center and Specialty Sunglass Store for Sale; in business 58 years, over 70 brands featured. Space for optometric practice. Near Mountains and the Great outdoors. $56,900 + Inventory, Call Tom Emerling, YBA (broker) at (406) 655-4241.

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Please look through your garage, closets, basement for all your unused books, equipment, instruments, stock frames and lenses and any items that might be of use to a Optometry school, a student or eye clinic. Instructions on how to proceed are available by going to the VOSH website (www.vosh.org) and click on Technology Transfer Program. The most desirable items that programs in developing countries need are: Trial lens kits, Battery powered hand scopes, Assorted Pliers and Optical Tools, Hand Stones for edging plastic lenses, uncut lenses (both SV and BF), Manual Lensometers, Phoropters, Lens Clocks, Color Vision Tests, Keratometers and Biomicroscopes. This list is certainly not complete but gives you an idea of some of the basic needs these developing programs can benefit from.
All items may be shipped directly to:
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Assistance with shipping cost may be available through your local Rotary or Lions Clubs. Contact www.vosh.org with any questions or email dpvc@juno.com and/or voshinternational@comcast.net.

Classified Advertising Information

Effective the January, 2012 issue onwards, Classified advertising rates are are as follows: 1 column inch = $75 (40 words maximum) 2 column inches -$125 (80 words maximum) 3 column inches = $165 (120 words maximum). This includes the placement of your advertisement in the classified section of the AOA Member Web site for two weeks. An AOA box number charge is $30.00 and includes mailing of responses. The envelope will be forwarded, unopened, to the party who placed the advertisement. Classifieds are not commissionable. All advertising copy must be received by e-mail at t.peppers@elsevier.com attention Tracie Peppers, Classified Advertising. You can also mail the ads to Elsevier, 360 Park Avenue South, 9th floor, New York, NY 10010.

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References: 1. Based on typical rebates and compliance with manufacturer-recommended lens replacement for DAILIES® AquaComfort Plus® and ACUVUE^ OASYS^, and lens care for ACUVUE^ OASYS^; Alcon data on file, 2012. **2.** Dumbleton K, Woods C, Jones L, et al. Patient and practitioner compliance with silicone hydrogel and daily disposable lens replacement in the United States. *Eye Contact Lens*. 2009;35(4):161-174. **3.** Stiegemeier MJ, Fahmy M, Thomas S. Beating back SAC. *Optometric Management*. 2008;43(9):84-85.

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References: 1. Data on file, Alcon Research Ltd, 2011. **2.** In a randomized, subject-masked clinical study at 20 sites with 252 patients; significance demonstrated at the 0.05 level. Alcon data on file, 2009. **3.** Rappon J, Bergenske P. AIR OPTIX® AQUA Multifocal contact lenses in practice. *Contact Lens Spectrum*. 2010; 25(3): S7-S9.

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